

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00191					00193				
1. PLACE OF DEATH COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 1 year 6 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park, Md d. STREET ADDRESS 1020 National Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Glady's First 101 Middle Anderson Last		4. DATE OF DEATH Month 1 Day 6 Year 1967							
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-94	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 1 Days 6		IF UNDER 24 HRS. Hours 16 Min. 2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK CROSMAN					14. MOTHER'S MAIDEN NAME ALICE SMITH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 578-54-0631		17. INFORMANT Records, Mount Wilson State Hospital Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 002.1 IMMEDIATE CAUSE (a) Pulmonary tuberculosis Far advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 weeks DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-26- , 1965, to 1-6 , 1967, that (I) (we) last saw the deceased alive on 1-6 , 1967, and that death occurred at 11P M, from the causes and on the date stated above.									
22a. SIGNATURE W. Newcomer					22b. DATE SIGNED Jan 6-67				
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent					22d. ADDRESS Mount Wilson, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9-1967		23c. NAME OF CEMETERY OR CREMATORY Addison Chapel		23d. LOCATION (City, town or county) (State) Seat Pleasant, Maryland.			
24. FUNERAL DIRECTOR Simmons Bros Wash DC 20002					REC'D BY REGISTRAR JAN 10 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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Baltimore County

Mount Allison

Mount Allison State Hospital

Mount Allison State Hospital
Records, Mount Allison State Hospital
Baltimore County, Maryland

Mr. Newcomer, H. D., Superintendent, Mount Allison, Maryland

Jan. 10-1907, All Rights Reserved, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00192

CERTIFICATE OF DEATH

00194

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 38 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2811 E. BIDDLE STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BENNIE Middle -- Last BAILEY		4. DATE OF DEATH Month JANUARY Day 9 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH AUGUST 28, 1902 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER		10b. KIND OF BUSINESS OR INDUSTRY GROCERY	9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) ISLE OF WRIGHT, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BEN BAILEY		14. MOTHER'S MAIDEN NAME MITTIE DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 220 07 31 97	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH METASTASIS DUE TO TO BONE MARROW Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 12/2/66 , 19__, to 1/9/67 , 19__, that (we) lost saw the deceased alive on 1/9/67 , 19__, and that death occurred at 12:48AM from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 1/9/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-12-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME ADDRESS 1701 LAURENS ST. BALTIMORE, MD.		25a. REC'D BY REGISTRAR 10 1967 DATE 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00193

CERTIFICATE OF DEATH

00195

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown	
c. LENGTH OF STAY IN 1b 22 days		d. STREET ADDRESS 3722 Offutt Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances Virginia Baker		4. DATE OF DEATH Month Jan. Day 3 Year 19 67	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1871
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton E. Baker		14. MOTHER'S MAIDEN NAME Emeline Frazier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-54-4241 T	
17. INFORMANT Address Randallstown Mrs. Kathryn Rankin-3722 Offutt Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebro vascular hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH small	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 15 Dec , 19 66 , to 3 Jan , 19 67 , that (I) (we) last saw the deceased alive on 3 Jan 19 67 and that death occurred at home , from causes and on the date stated above			
22a. SIGNATURE William Goodman, MD		22b. DATE SIGNED 4 Jan 67	
22c. PHYSICIAN'S NAME (Type) Dr. Wm. Goodman		22d. ADDRESS 1334 Sulphur Spring Rd. 21227	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/5/67	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	23d. LOCATION (City or Town) (County) (State) Chestertown, Md.
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00196

00194

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Arrowship Road		d. STREET ADDRESS 14 Arrowship	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Rebecca Baldwin		4. DATE OF DEATH Month Day Year January 3 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1888
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Rose		14. MOTHER'S MAIDEN NAME Annie Rose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George W. Baldwin		Address 14 Arrowship Road	
18. CAUSE OF DEATH [Enter only one cause primary for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colony Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension + A-S-CV-Disease (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE MB Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 3, 1967	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/67	
22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.		24a. REC'D BY REGISTRAR JAN 5 1967	
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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January 2, 1937
In accordance with

January 2, 1937
New York, N.Y.

U.S.A.
George W. Brown
Anna Brown

Agreement + A-2-C-V-Division
George W. Brown

None

McBrown

Jan. 2, 1937
600 Lexington Road
Baltimore, Md.
London Park Company
Official Funeral Home, Baltimore, Md.

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00195					00197					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY _____					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30.4</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>					d. STREET ADDRESS <u>2818 W. Cold Spring Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle _____ Last <u>Bard</u>					4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>19 67</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Caplan</u>					14. MOTHER'S MAIEN NAME <u>Anna Tucker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-05-1222A</u>		17. INFORMANT Address <u>Mr. Albert C. Bard, 1323 Fidelity Building</u> #1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>420.0</u> OUE TO (b) <u>arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } OUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____ at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 22, 1965</u> to <u>Jan 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 15, 1967</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Manuel Levin</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>1/15/67</u>				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u>				22d. ADDRESS <u>4818 REISTERSTOWN RD BALTIMORE MD</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JAN 20 1967</u>						

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. File along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

00196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00198

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. LENGTH OF STAY IN lb 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5516 DOLORES Ave + 27				d. STREET ADDRESS 1722 WILKENS Ave + 23		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle MARGARET Last BARNETTE				4. DATE OF DEATH Month JANUARY Day 21 Year 1967			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5/8/1915	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 Year Months 1 Days 21 Hours 21 Min.		IF UNDER 24 HRS. Hours 21 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY MONTG. WARD		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER LUX				14. MOTHER'S MAIDEN NAME MARGARET HOFMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NA		16. SOCIAL SECURITY NO. 25-09-1427		17. INFORMANT MRS. M. LUX-MOTHER, ARBUTUS, MD.		Address 5516 DOLORES	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 199.2 IMMEDIATE CAUSE (a) CANCER OF THE ABDOMEN DUE TO BIRTH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edmund Kasaitis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/21/67	
EXAMINER'S NAME (Type) EDMUND KASAITIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/24/67		23c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Ambrose, Inc 1528 Sulphur Spring Rd.				25a. REC'D BY REGISTRAR JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00100

00100

00197

CERTIFICATE OF DEATH

00199

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 13 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS Hawthorne Road	
3. NAME OF DECEASED (Type or print) First Samuel Middle Jay Last BACHELOR		4. DATE OF DEATH Month 1 Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-47
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR Months 19 Days 67	11. IF UNDER 24 HRS. Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Herbert Batchelor	
14. MOTHER'S MAIDEN NAME Helen Frances Elbourn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 3255 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MENTAL RETARDATION (EPILEPSY) DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from 10-20 , 19 53 , to 1-13 , 19 67 , that (we) last saw the deceased alive on 1-13 , 19 67 , and that death occurred at 8:30am , from causes and on the date stated above.	
22a. SIGNATURE Harry G. Butler M.D.		22b. DATE SIGNED 1-13-67	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 14	23c. NAME OF CEMETERY OR CREMATORY Wesley CHAPEL	23d. LOCATION (City or town) (County) (State) Rock Hall MD.
24. FUNERAL DIRECTOR Edgar L. Lane Church Hill Md.		25a. REC'D BY REGISTRAR DATE JAN 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00100

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00498						CERTIFICATE OF DEATH			00200		
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN It <u>65 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16 Bond Avenue</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> <u>13.1</u> d. STREET ADDRESS <u>16 Bond Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Flavilla Harrison Battle</u> First Middle Last						4. DATE OF DEATH <u>January 22, 1967</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1902</u> Day Month Year		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Reisterstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louis Harrison</u>						14. MOTHER'S MAIDEN NAME <u>Elsie Waters</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-32-1840</u>		17. INFORMANT <u>Mr. Charles Battle</u> Address <u>16 Bond Ave. Reisterstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic C.V. Disease</u> (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulcerative Colitis</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 9, 1952</u> to <u>Jan. 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19, 1967</u> and that death occurred at <u>10AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Martin E. Strobel</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-23-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>						22d. ADDRESS <u>48 Main St. Reisterstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Reisterstown, Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Schhardt</u>				ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00390

92300

10/10/10

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00139

CERTIFICATE OF DEATH

00201

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 143 Oaklee Village		d. STREET ADDRESS 143 Oaklee Village	
3. NAME OF DECEASED (Type or print) LOUIS F. BATZER		4. DATE OF DEATH January 6, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Batzer		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Bernard C. Batzer, 603 Ralston Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive-arterio-vascular C.V.D. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT. 9, 1948 , to Jan 7, 1967 , that (I) (we) last saw the deceased alive on Dec 31, 1966 , and that death occurred at 8 A M. from causes and on the date stated above.			
22a. SIGNATURE Kennard Yaffe		22b. DATE SIGNED 1/8/67	
22c. PHYSICIAN'S NAME (Type) Dr. Kennard Yaffe		22d. ADDRESS 5501 Forest Park Ave. Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-9-1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JAN 10 1967	
25b. REGISTRAR'S SIGNATURE John H. Hubbard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00130

00301

RECEIVED

TO THE HONORABLE
SPEAKER OF THE HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.
FROM THE
[Illegible Name]
[Illegible Address]
[Illegible City, State, Zip]
[Illegible Title]
[Illegible Date]
[Illegible Subject]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

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28

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00200					CERTIFICATE OF DEATH			00202	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 2897 Willoughby Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Beck					4. DATE OF DEATH Month Jan. Day 21 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-1-26 95.		9. AGE (In years last birthday) yrs. 20 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Cont. Can Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry L. Beck					14. MOTHER'S MAIDEN NAME Sophia Hoffman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 216-05-1726		17. INFORMANT Mrs. Naomi Riggleman Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myelogenous Leukemia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 14, 1967 , to Jan. 21, 1967 , that (1) (we) last saw the deceased alive on Jan. 21, 1967 , and that death occurred at 12:05 AM , from causes and on the date stated above.									
22a. SIGNATURE Elmo M. Gayoso					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED Jan/ 21, 1967	
22c. PHYSICIAN'S NAME (Type) Elmo M. Gayoso					22d. ADDRESS 7620 York Road- Towson 21204, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/24/67.		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE JAN 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00201

CERTIFICATE OF DEATH

00203

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rual</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2 Glenmore Avenue #36</u>		d. STREET ADDRESS <u>2 Glenmore Avenue #36</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>O</u> Last <u>Becker</u>		4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1880</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Electric Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund Becker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Bosley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-3215</u>	
17. INFORMANT <u>Mrs Edith Walters</u>		Address <u>7515 Kenlea Avenue 36</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary occlusion</u> (b) <u>Coronary occlusion</u> DUE TO <u>Coronary occlusion</u> (c) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcium, blood</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10 Feb</u> , 19 <u>65</u> , to <u>4 Jan</u> , 19 <u>67</u> , that (I) (we) lost said the deceased alive on <u>4 Jan 1967</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Howard Goodman</u>		22b. DATE SIGNED <u>6 Jan 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>		22d. ADDRESS <u>4604 K... Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00303

STATE OF TEXAS

00303

THE STATE OF TEXAS, COUNTY OF DALLAS, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County Clerk of said County.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

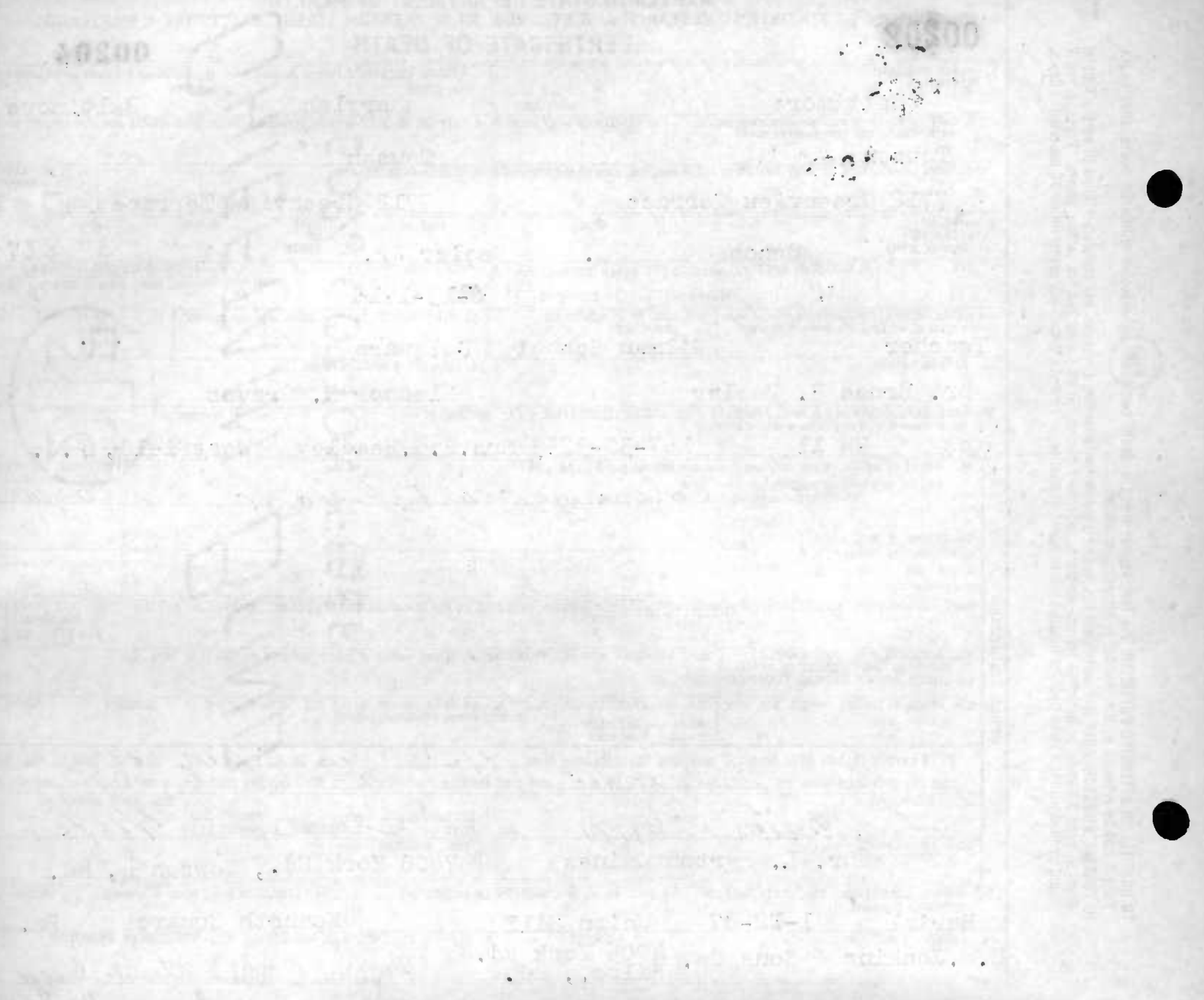
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00202 CERTIFICATE OF DEATH 00204											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 13.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7712 Greenview Terrace						d. STREET ADDRESS 7712 Greenview Terrace					
3. NAME OF DECEASED (Type or print) First Bruce Middle H. Last Beeler Jr.						4. DATE OF DEATH Month 1 Day 9 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-13-1918		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 1 Days 9 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Gilman School		11. BIRTHPLACE (County & State, or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Dr. Bruce H. Beeler						14. MOTHER'S MAIDEN NAME Eleanor R. Graves					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11				16. SOCIAL SECURITY NO. 167-30-3253		17. INFORMANT Mrs. F.G. Headley Address Westfield, N.J.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/5 , 19 63 , to January , 19 67 , that (I) (we) last saw the deceased alive on December 29 1966 , and that death occurred at 2 A M, from the causes and on the date stated above.											
22a. SIGNATURE L. Myrton Gaines						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/10/67			
22c. PHYSICIAN'S NAME (Type) Dr. L. Myrton Gaines						22d. ADDRESS 7800 York Rd., Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-67		23c. NAME OF CEMETERY OR CREMATORY Union Hill			23d. LOCATION (City, town or county) (State) Kenneth Square Pa.				
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						ADDRESS 4905 York Rd. Balto., Md.		25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00203					CERTIFICATE OF DEATH			00205	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21207			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21207 13.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3114 Rolling Road					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hattie			First Lena		Middle Bennett		Last		4. DATE OF DEATH Month Jan. Day 22 Year 19 67
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/1895		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) South Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Peale					14. MOTHER'S MAIDEN NAME Sally Odam				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Lawrence H. Calhoun-3114 Rolling Rd. 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Central Apoplexy - Stroke DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 16 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 11 , 19 67 , to Jan 22 , 19 67 , that (I) (we) last saw the deceased alive on Jan 21 , 19 67 , and that death occurred at 3:15 A.M. from causes and on the date stated above									
22a. SIGNATURE Edwin Pierpont					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/23/67		
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Pierpont					22d. ADDRESS 8204 Liberty Road-Balt. 21207				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/1967		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial			23d. LOCATION (City or Town) (County) (State) Finksburg, Md.		
24. FUNERAL DIRECTOR Loring Byers					25a. REC'D BY REGISTRAR 8728 Liberty Rd. Randallstown		25b. REGISTRAR'S SIGNATURE JAN 25 1967 <i>Charles Judge</i>		

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00204						CERTIFICATE OF DEATH			00206		
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAWSON</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annstie</u>				d. STREET ADDRESS <u>506 Murdock Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO. MED CTR</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>RAMER</u> Last <u>BENSON</u>						4. DATE OF DEATH Month <u>JAN.</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 24 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles Ramer</u>						14. MOTHER'S MAIDEN NAME <u>Mary Schwaab</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Charles T Benson</u>			Address <u>1628 Ingram Rd 21212</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> 154X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>CARCINOMA OF RECTUM.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 30</u> , 19 <u>66</u> , to <u>Jan. 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5</u> , 19 <u>67</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John E. Adams, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>JAN. 6, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. ADAMS, M.D.</u>						22d. ADDRESS <u>GREATER BALTO. MED. CTR.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>JAN 6 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore MD</u>			
24. FUNERAL DIRECTOR <u>Burder Funeral Home</u>						ADDRESS <u>3631 Falls Rd Balto</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JAN 9 1967</u>											

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00205

CERTIFICATE OF DEATH

00207

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove Hosp</u>		d. STREET ADDRESS <u>Fairview Farms</u>	
3. NAME OF DECEASED (Type or print) First <u>Dan</u> Middle <u>FRANKLIN</u> Last <u>Billmyer Jr.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>METAL FINISHERS</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dan F. Billmyer Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Nancy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>218-09-3492</u>	
17. INFORMANT <u>Mrs. Agnes M. Schmidt</u>		Address <u>Winnons Rd Randallstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Pneumonia</u> (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>67</u> , to <u>1/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>67</u> , and that death occurred at <u>2:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur C. Lamb Jr.</u>		22b. DATE SIGNED <u>1/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur C. Lamb, Jr. M.D.</u>		22d. ADDRESS <u>Spring Grove Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank Russell Jr. Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Baltimore Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 6</u>		19 <u>67</u>	

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FOR STATE HEALTH DEPT.

00206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00208

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 5 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 202 E. Seminary Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET ADELE BIRD		4. DATE OF DEATH Month January Day 1 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-14
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Okalona, Ark		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J.E.Cooper		14. MOTHER'S MAIDEN NAME Velma Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 577-36-2594	
17. INFORMANT Carroll Bird, Lutherville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 322.0 IMMEDIATE CAUSE (a) Acute ethylism DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED January 1, 1967 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 1-4-67	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25. REC'D BY REGISTRAR DATE JAN 4 1967	
26. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00207

CERTIFICATE OF DEATH

00209

Item 3 Film G504 1/11/67

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GARRISON c. LENGTH OF STAY IN 1b 7mo 29days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FOXLEIGH NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO CITY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO. d. STREET ADDRESS 3830 Park Heights Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ann Middle Evans Last R. B. C. K.	4. DATE OF DEATH Month 1 Day 7 Year 1967	5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/1894	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Taylor		14. MOTHER'S MAIDEN NAME Georgeanna Berry		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-8147		17. INFORMANT Mrs. Georgeanna Carberry, 5960 Daywalt Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH Hours unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 5-9 , 1966, to 1-7 , 1967, that (1) (we) last saw the deceased alive on 1-5 , 1967, and that death occurred at 3:45 PM , from the causes and on the date stated above.									
22a. SIGNATURE David I. Miller		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-7-67		22c. PHYSICIAN'S NAME (Type) David I. Miller			
22d. ADDRESS Linson Rd. Owings Mills, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/10/67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville, Balto. Co. Md.			
24. FUNERAL DIRECTOR B. Vernon Lemmons		ADDRESS 4611 Park Heights Av. Balto. Md.		25a. REC'D BY REGISTRAR JAN 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Housewife

At home

At home

George Taylor

George Taylor

52-11-100

52-11-100

Housewife

1/10/67

1/10/67

1/10/67

1/10/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00208

CERTIFICATE OF DEATH

00210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 1wk.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights - Baltimore		21090 02-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 430 W. Shipley Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle C. Last Blumenberg		4. DATE OF DEATH Month January Day 17th Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-13
9. AGE (In years lost birthday) yrs. 53		IF UNDER 1 YEAR Months 12 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Ohio (Limaville)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse D. Clark		14. MOTHER'S MAIDEN NAME Grace Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 300-01-0178	
17. INFORMANT Mr. Karl E. Blumenberg (Husband)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 550.1 IMMEDIATE CAUSE (a) Generalized peritonitis DUE TO (b) acute appendicitis. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia due to chronic glomerulonephritis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that NO (this hospital) attended the deceased from Jan. 9 , 19 67 , to Jan. 17 , 19 67 , that NO (we) last saw the deceased alive on Jan. 17 , 19 67 , and that death occurred at 11:50 M, from causes on and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik		22b. DATE SIGNED January 18, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Glen Boven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Eugene B. Fleming		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 19 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00209						00211					
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MED. CTR.						d. STREET ADDRESS 933 W. LOMBARD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CECELIA		First		Middle BERTHA		Last BOLTON		4. DATE OF DEATH Month JANUARY		Day 30	
5. SEX F		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-13-03		9. AGE (in years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB KOWALEWSKI						14. MOTHER'S MAIDEN NAME FELICIA KOWALEWSKI					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. 240-24-2086		17. INFORMANT DOROTHY WITHROW Address 1044 W. LOMBARD ST. BALTO., MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-28 , 19 67 , to 1-30 , 19 67 , that (I) (we) last saw the deceased alive on 1-30 , 19 67 , and that death occurred at 4 P M, from the causes and on the date stated above.											
22a. SIGNATURE M. A. Gongon						M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-30-67			
22c. PHYSICIAN'S NAME (Type) MANUEL A. GONGON						22d. ADDRESS Greater Balto Med. Center					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/3/67		23c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR John J. Cowan & Sons Inc.						ADDRESS Hollins St. 23, Md.		25a. REC'D BY REGISTRAR FEB 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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WASH DC

BALTIMORE

BALTIMORE

3 days

CENTER BALTIMORE MD CTR 933 W. COMBARD

CECELIA BETHA BOLTON

F CAN X

9-12-03

HONSEWIFE BALTIMORE, MD

JACOB KOWALEWSKI

TELVIC KOWALEWSKI
DOROTHY WITKOWSKI 1046 W COMBARD ST
BALD, MD

Anterior cingulate Gyrus
Acute Infarction
Subcortical Infarction

1930

MANUEL A. GONGON

1-28

1-30

27

X

1-30-03

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00210					00212				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY BALTIMORE					a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD					b. COUNTY WICOMICO				
c. LENGTH OF STAY IN lb 269 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS 610 SOUTH DIVISION STREET				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last LEONARD - - - BOZMAN					Month Day Year JANUARY 27 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1891		9. AGE (In years lost birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PRINCESS ANNE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EMORY BOZMAN					14. MOTHER'S MAIDEN NAME ANNIE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 220 10 95 04		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROSIS MARKED GENERALIZED								INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT & OLD UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY. DIABETES MELLITUS, CLINICAL								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from MAY 3 , 19 66 , to JAN. 27 , 19 67 , that (we) last saw the deceased alive on JAN. 27 , 19 67 , and that death occurred at 8:40 PM , from causes on and on the date stated above.									
22a. SIGNATURE <i>George Dudas</i>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/30/67		
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.					22d. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/1/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR <i>173 Zannino</i>					25a. REC'D BY REGISTRAR FEB 1 1967		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		
ZANNINO FUNERAL HOME 257 S. Conkling St. Baltimore, Md.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

00211

00213

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 84 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS ROUTE 2, BOX 2A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELMER Middle THOMAS Last BROWN			4. DATE OF DEATH Month JANUARY Day 27 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPTEMBER 1, 1892		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LAUREL, MARYLAND	
13. FATHER'S NAME BENJAMIN BROWN			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 219 05 77 87		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF STOMACH DUE TO (c) UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RECENT MYOCARDIAL INFARCTION					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that NY (this hospital) attended the deceased from NOV 1 , 19 66 , to JAN. 27 , 19 67 that NY (we) last saw the deceased alive on JAN. 27 19 67 , and that death occurred at 545PM , from causes and on the date stated above.					
22a. SIGNATURE Z. S. Tao		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-27-67	
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-30-67		23c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEMETERY	
23d. LOCATION (City or Town) (County) (State) LAUREL, MARYLAND					
24. FUNERAL DIRECTOR DEWITT DONALDSON		ADDRESS 313 TALBOT AVENUE, LAUREL, MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 6 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00212					CERTIFICATE OF DEATH			00214		
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 Butler Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 101 Butler Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Elwood Middle Eugene Last Brown					4. DATE OF DEATH Month January Day 25 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1931		9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hampstead, Md.		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Havern Brown					14. MOTHER'S MAIDEN NAME Wiona Martin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Korean		17. INFORMANT Mrs. Mary A. Brown		Address Reisterstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Carcinoma - Colon & metastasis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 months										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from September 19 66 , to January 25 19 67 , that (I) (we) last saw the deceased alive on January 25 19 67 , and that death occurred at 9:25 AM , from causes and on the date stated above.										
22a. SIGNATURE Charles E. M. Williams M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-26-67			
22c. PHYSICIAN'S NAME (Type) _____					22d. ADDRESS 11904 Reisterstown Rd Reisterstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/28/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.				
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.					ADDRESS _____		25a. REC'D BY REGISTRAR JAN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2:500

SIS90

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00213					00215				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville					b. COUNTY Balto.				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7803 Old Harford road					d. STREET ADDRESS 7803 Old Harford road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
VIRGINIA C. BRUCK						Jan 30		1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9 1910	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Carroll Clark				14. MOTHER'S MAIDEN NAME Myrtle Rice					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-6643		17. INFORMANT Family Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-3-1965, to 1-30-1967 that (I) (we) last saw the deceased alive on 12-30-1967, and that death occurred at 7 PM, from the causes and on the date stated above.									
22a. SIGNATURE E. Ellsworth Cook				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-31-67-	
22c. PHYSICIAN'S NAME (Type) E. Ellsworth Cook M.D.				22d. ADDRESS 2431 Maryland Ave.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		23d. LOCATION (City, town or county) (State) Balto Co Md.			
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 2 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

6500

00214

CERTIFICATE OF DEATH

00216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 20.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21224 d. STREET ADDRESS 7 Ellwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle H. Last Buettner				4. DATE OF DEATH Month January Day 15 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1889	9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months 77 Days 15 Hours 19 Min. 67	IF UNDER 24 HRS. Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired:		10b. KIND OF BUSINESS OR INDUSTRY Building Superintendent		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Buettner				14. MOTHER'S MAIDEN NAME Clara ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9074A		17. INFORMANT Mrs. Lillian Buettner Address 7 N. Ellwood Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.3 (b) Perforation of Adenocarcinoma of Sigmoid Colon DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that he (this hospital) attended the deceased from January 12, 1967 , to January 15, 1967 , that he (we) last saw the deceased alive on January 15, 1967 , and that death occurred at 3:25 P. M., from causes and on the date stated above.							
22a. SIGNATURE Reynaldo Orjuela-Gomez, M. D.		22b. DATE SIGNED January 15, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M. D.			
22d. ADDRESS 7620 York Road, Towson 4, Md.		22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/19/67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)		
24. FUNERAL DIRECTOR John A. Moran, Inc.		25a. REC'D BY REGISTRAR Jan 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

00316

TESTIMONY OF DEATH

00316

NAME

NAME

AGE

AGE

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

DATE

DATE

TIME

PLACE

TESTIMONY OF DEATH

TESTIMONY OF DEATH

NAME

NAME

AGE

AGE

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

DATE

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TESTIMONY OF DEATH

TESTIMONY OF DEATH

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ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

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PLACE

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00215

CERTIFICATE OF DEATH

00217

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		d. STREET ADDRESS <u>Mt. Vista Road Kingsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Towson Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Burgerding</u> Last <u>Burgerding</u>		4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1897</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick L. Frey</u>		14. MOTHER'S MAIDEN NAME <u>Pauline C. Eekes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 48 1325</u>	
17. INFORMANT <u>Mrs Marguerite Hess</u>		Address <u>8809 Ashford Road 34</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro intestinal ? hemorrhage</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectum - widespread</u> DUE TO <u>metastases</u> (c) <u>metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 21</u> , 19 <u>67</u> , and that death occurred at <u>7:40 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Charles M. Kerr</u>		22b. DATE SIGNED <u>1-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles M. Kerr</u>		22d. ADDRESS <u>6801 Belvoir Rd Baltimore 9 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-26-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belvoir Road</u>		25a. REC'D BY REGISTRAR <u>31</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 25 1967</u>	

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00216

CERTIFICATE OF DEATH

00218

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10mth 22dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1421 Hill Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Cadden		4. DATE OF DEATH Month January Day 6 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1910
9. AGE (In years last birthday) yrs. 56		10. BIRTHPLACE (County & State, or foreign country) Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife Sect.		10b. KIND OF BUSINESS OR INDUSTRY Office	
13. FATHER'S NAME George Walfer		14. MOTHER'S MAIDEN NAME Carrie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-9953	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis, chronic (c) Diabetes Mellitus, poorly controlled		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 yr. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Feb. 11, 1966 to Jan. 6, 1967 , that (he) (we) last saw the deceased alive on Jan. 6, 1967 , and that death occurred at 1:30 M, from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 1-6-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1 10 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave	
25a. REC'D BY REGISTRAR JAN 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00318

00318

INSTITUTIONAL REPORT

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00217

CERTIFICATE OF DEATH

00219

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONKTON - MONKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - MONKTON 03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monkton Rd., Near Old York Rd.</u>		d. STREET ADDRESS <u>Monkton Rd., near Old York Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY G. CANNADAY</u>		4. DATE OF DEATH <u>JAN. 2 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1895 NOV. 23, 1903</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC T. CANNADAY</u>		14. MOTHER'S MAIDEN NAME <u>LUCY PETERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1/22.1</u> IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO (b) <u>A.S.C.V.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>67</u> , to <u>1/2/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1/2/67</u> 19 <u> </u> , and that death occurred at <u>10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. France</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/3/67</u>
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JAN. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>MONKTON, BALTOCO, MD.</u>
24. FUNERAL DIRECTOR <u>John Burno' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>	25b. REGISTRAR'S SIGNATURE <u>gcharles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

00218

CERTIFICATE OF DEATH

00220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 56 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3026 BAKER STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT		First WALTER		Middle CARRINGTON		Last CARRINGTON		4. DATE OF DEATH Month JANUARY	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 28, 1942		9. AGE (In years last birthday) 24 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock boy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN CARRINGTON				14. MOTHER'S MAIDEN NAME AMIE PEGRAM					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 214 38 60 61		17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL LOBAR PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) MULTIPLE SCLEROSIS								INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV 10 , 19 66 to JAN 5 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JAN 5 , 19 67 , and that death occurred at 9:45 A.M. , from causes and on the date stated above.									
22a. SIGNATURE <i>He-lan he-lan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 1/6/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-10-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				ADDRESS CHARLES R. LAW FUNERAL HOME 802 MADISON AVENUE, BALTIMORE, MD.		25a. REC'D BY REGISTRAR DATE 9, 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

05500

1992

00219

CERTIFICATE OF DEATH

00221

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 8 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 128 E. BARNEY STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle L. Last CATLETT		4. DATE OF DEATH Month JANUARY Day 23 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/28/18
9. AGE (In years) 48		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY ARMY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CIARENCE CATLETT		14. MOTHER'S MAIDEN NAME ELLEN CHILDRESS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PL 28		16. SOCIAL SECURITY NO. 216 01 86 97	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT LOWER LOBE PNEUMONIA, UNDETERMINED ORGANISM DUE TO (b) HEPATIC FAILURE DUE TO (c) LAENNEC'S CIRRHOSIS		INTERVAL BETWEEN ONSET AND DEATH DAYS ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE. CHRONIC ALCOHOLISM. CHR. PANCREATITIS.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 1/15/67 , 19 67 , to 1/23/67 , 19 67 , that (we) last saw the deceased alive on 1/23/67 , 19 67 , and that death occurred at 12:10PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Neilon Neilson</i>		22b. DATE SIGNED 1/23/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1 27 67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME		25a. REC'D BY REGISTRAR JAN 25 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00220

CERTIFICATE OF DEATH

00222

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLS TOWN</u>		c. LENGTH OF STAY IN 1b <u>15 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. Co. Gen. Hosp</u>		e. STREET ADDRESS <u>Box 185 Liberty Road</u>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Carlton E Charnock</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Plant Cold Storage</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. Co. Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Howard Charnock</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Dize</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>14-16-3631</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RIGHT PHRENIC NERVE PARALYSIS</u> DUE TO (b) <u>METASTASIS, CA OF THE LUNGS</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-27-1966</u> , to <u>1-10-1967</u> , that (I) (we) lost the deceased on <u>1-10-1967</u> , and that death occurred at <u>4:04 A.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>DR MORTON ELLIN</u>		22b. DATE SIGNED <u>1-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR MORTON ELLIN</u>		22d. ADDRESS <u>8629 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>
24. FUNERAL DIRECTOR <u>Shelburne & Son 3207 W. North Ave</u>		25. REC'D BY REGISTRAR DATE <u>JAN 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00333

UNITED STATES OF AMERICA

00330



FOR STATE
HEALTH DEPT.

00221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00223

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 12		c. LENGTH OF STAY IN 1b <u>03-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>316 CASTLE DRIVE</u>		d. STREET ADDRESS <u>516 CASTLE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>C.</u> Last <u>CHARSHA</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED W. CURRY</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. QUIGLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>220-44-0851</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>HYPERTENSIVE CEREBRO-VASCULAR DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William A. Pillsbury</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>John B. Jones</u> M.D. Address (Street, City, Town, or County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>	23b. DATE THEREOF <u>2-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT MAUSOLVM</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00222

CERTIFICATE OF DEATH

00224

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 6908 Old Harford Rd.	
3. NAME OF DECEASED (Type or print) First Margaret Middle Emma Last Chelton		4. DATE OF DEATH Month January Day 27 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/91
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 27 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Murphy		14. MOTHER'S MAIDEN NAME Bridget Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-12-5671	
17. INFORMANT Mr. George W. Chelton		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 16 , 19 67 , to Jan. 27 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 27 , 19 67 , and that death occurred at 9:45 PM , from causes and on the date stated above.			
22a. SIGNATURE M. Y. Chang		22b. DATE SIGNED Jan. 27 1967	
22c. PHYSICIAN'S NAME (Type) Myung Y. Chang		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/31/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00330

00334


STATE OF TEXAS

M. J. Chief

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00223					00225					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		Baltimore			a. STATE		b. COUNTY			
		MARYLAND			Maryland		✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Towson					Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Dulaney Towson Nursing Home, 111 West Rd					3115 Keswick Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		
		MARY		E.		CHENOWITH		Month Day Year		
								January 2 1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9-14-1880		86 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housewife			-			Warrenton, Virginia			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Alexander M. Edwards					Mary Catherine Gray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT					
No			-		John A. Chenowith, 3725 Delverne Rd 21218					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREbro - vAScULAR ACCIDENT								MINUTES		
331X DUE TO CEREbral ARTERIOsCLEROSIS								YEARS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from 7/13, 1965, to 1/2, 1967, that (I) (we) last saw the deceased alive on 12/28 1966, and that death occurred at 1:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
Donald L. Somerville					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			1/4/67		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
Dr. Donald L. Somerville					25 W. Pennsylvania Ave., Towson 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial		6 Jan 1967		Lorraine Park Cemetery		Woodlawn, Balto. Co., Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR				
Burgee Funeral Home, 3631 Falls Rd. Balto. Md.						25b. REGISTRAR'S SIGNATURE				
By: Harold Burgee Jr						DATE JAN 5 1967 Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00224

00226

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE, MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston MARYLAND 05-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE First MARIE Middle Center Last CLARK</u>				4. DATE OF DEATH <u>JANUARY 22 1967</u>			
5. SEX <u>FEMALE CAUC</u>		6. COLOR OR RACE <u>WHITE</u>		7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1896 3/14/96</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>EAST New Market MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John T. Schmick</u>				14. MOTHER'S MAIDEN NAME <u>Catherine M. SHAWERMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>219-14-3750</u>		17. INFORMANT <u>PATIENTS CHART</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>state of unconsciousness</u> (c) <u>Ruptured Cerebral Aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN - 19</u> , 19 <u>67</u> , to <u>JAN. 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-22</u> 19 <u>67</u> , and that death occurred at <u>1050 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M. A. Gongon</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Maryland</u>				25a. REC'D BY REGISTRAR <u>FEB 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00230

00230

Rupert's (Gordon) Freeman
State of Massachusetts
Aspirator Freeman

JAN 19 1969 JAN 25 1969

MANUEL A. GORDON
1-25 69

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00225

CERTIFICATE OF DEATH

00227

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 28 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. CO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 805 JEFFERIES STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VERNON ROBERT CLARKE			4. DATE OF DEATH Month Day Year JANUARY 4 1967				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 24, 1908	9. AGE (In years last birthday) yrs. 58	10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ser Sta Attendant		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME 				
14. MOTHER'S MAIDEN NAME 		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II					
16. SOCIAL SECURITY NO. 217 07 62 71		17. INFORMANT Address CLINICAL RECORDS FORT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL TRACHEA FISTULA DUE TO (b) CARCINOMA OF UPPER ESOPHAGUS DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH MINUTES		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC 7 , 19 66 , to JAN 4 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JAN 4 , 19 67 , and that death occurred at 800 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 1/5/67		22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.			
22d. ADDRESS VAH FORT HOWARD, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					
23b. DATE THEREOF 1/9/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE ANATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME FORT AVENUE, BALTIMORE, MD.		25a. REC'D BY REGISTRAR DATE JAN 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00222

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00226

00228

1. PLACE OF DEATH a. CITY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>400 Murdock Road</u> <u>23.1</u> d. STREET ADDRESS <u>Baltimore Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>N.M.N.</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1967</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/85</u>			
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Patrick Kennedy</u>			14. MOTHER'S MAIDEN NAME <u>Mary Kennedy</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-54-34</u>		17. INFORMANT <u>Mrs. Charles Heinmuller</u> Address <u>400 Murdock Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> (b) <u>Cerebral vascular accident + Bronchopneumonia</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>January 23, 1967</u> , to <u>January 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 24, 1967</u> , and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Juan L. Roque</u> 22c. PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>				22b. DATE SIGNED <u>1/25/67</u> 22d. ADDRESS <u>6701 N. Charles St. Balto 21204 MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u> ADDRESS <u>6500 York Rd. Balto., Md. 21212</u>					
25a. REC'D BY REGISTRAR <u>JAN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

MEDICAL CERTIFICATION

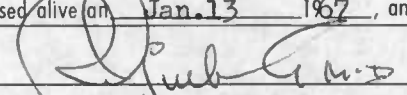
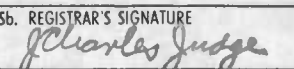
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00227

CERTIFICATE OF DEATH

00229

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21234			d. STREET ADDRESS 8219 Wilson Ave.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vaslan Middle B. Last Colwell		4. DATE OF DEATH Month Jan. Day 13 Year 1967		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/30/15		9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Splicer		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph B. Colwell				14. MOTHER'S MAIDEN NAME Bessie G. Lent			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war and dates of service) yes		16. SOCIAL SECURITY NO. 216-01-6917		17. INFORMANT Mrs. Valeria G. Thomas		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis, acute. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Severe arteriosclerosis of coronary arteries 2) pulmonary edema						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 13 , 19 67 , to Jan. 13 , 19 67 , that 4 (we) last saw the deceased alive on Jan. 13 , 19 67 , and that death occurred at 9:30 PM , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED January 14, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.	
22d. ADDRESS 7620 York Road, Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/67.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE JAN 18 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body, and in any event, within 72 hours after death.

ESS00

USSR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00228 CERTIFICATE OF DEATH 00230

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY _____											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Leatonsville</u>		c. LENGTH OF STAY IN <u>5 months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30.4</u>		d. STREET ADDRESS <u>121 S. Schroeder St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Nursing Home</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>1st</u> Year <u>1967</u>											
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Conroy</u> Last _____		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/96</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mines</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>-P</u>				17. INFORMANT <u>Mrs Janet Lewis</u>				Address <u>121 S. Schroeder St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA + ANEURYSM</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>CHRONIC SEVERE CHRONIC UNACCUSED DISEASE</u> DUE TO (c) <u>CHRONIC SEVERE - PULMONARY EMPHYSEMA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/1966</u> to <u>1/1/1967</u> , that (I) (we) last saw the deceased alive on <u>1/1/1967</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>John H. Shaw</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>1/4/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>				22d. ADDRESS <u>5801 Edmondson Ave. Baltimore, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>01/05/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town or county) _____ (State) _____									
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Corran</u>				ADDRESS <u>23, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Corran</u>					

ASSOCIATION

00229

CERTIFICATE OF DEATH

00231

1. PLACE OF DEATH a. COUNTY Towson BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. #21204		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SISTER M. OCTAVIA Middle CONROY Last CONROY		4. DATE OF DEATH Month Jan. Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious	9. AGE (In years last birthday) 79 yrs.
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Conroy		14. MOTHER'S MAIDEN NAME Mary Kearney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Sister Catherine Rita	
17. INFORMANT (Same)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary thrombosis, right.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-27-66 , 19 19 , to 1-19 , 19 67 that (I) (we) last saw the deceased alive on 1-19-67 , 19 19 , and that death occurred at 4:35 PM , from causes and on the date stated above.			
22a. SIGNATURE Arturo A. Pidlaon M.D.		22b. DATE SIGNED 1-19-67	
22c. PHYSICIAN'S NAME (Type) Arturo Pidlaon, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/23/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00230				CERTIFICATE OF DEATH			00232			
1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN lb 32 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - Dundalk				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS 8053 DELHAVEN ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last FRED -- COOPER Sr.					4. DATE OF DEATH Month Day Year JANUARY 31 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 17, 1894		9. AGE (In years last birthday) yrs. 72		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Watchman		10b. KIND OF BUSINESS OR INDUSTRY Coal Co.		11. BIRTHPLACE (County & State, or foreign country) WOLF COUNTY, KENTUCKY			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALFRED F. COOPER					14. MOTHER'S MAIDEN NAME SARABELLE ROBERTS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 401 28 91 63		17. INFORMANT Address CLIN. REC., VAH, FT. HOWARD, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIVER 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) BRONCHOPNEUMONIA. ARTERIOSCLEROTIC HEART DISEASE									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that he (this hospital) attended the deceased from Dec. 30, 1966 , to Jan. 31, 1967 that he (we) last saw the deceased alive on Jan. 31, 1967 , and that death occurred at 1:15 a. M, from causes and on the date stated above.										
22a. SIGNATURE <i>John D. Talbert</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/31/67				
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VAH, FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/3/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR John J. Duda				ADDRESS DUDA FUNERAL HOME		25a. REC'D BY REGISTRAR DATE FEB 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
7922 WISE AVENUE, BALTIMORE, MD.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
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VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>few months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bloombury Retreat, 200 Bloombury Ave.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>8346 Ridgely Oak Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie W. Coursey</u>						4. DATE OF DEATH Month Day Year <u>Jan. 5, 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14, 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-05-9642A</u>		17. INFORMANT <u>Madge V. Duvall (Daughter)</u>		Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC C V DISEASE</u> DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>VIRUS INFLUENZA. CHRONIC CYSTITIS.</u>										INTERVAL BETWEEN ONSET AND DEATH. <u>5 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>VIRUS INFLUENZA. CHRONIC CYSTITIS.</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 5, 1966</u> to <u>JAN 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 5, 1967</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul R. Ziegler</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>PAUL R. ZIEGLER</u>						22d. ADDRESS <u>200 CHESTNUT AVE. DR. FAIRGATE CITY, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> <u>MD 21043</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Eugenia K. Seitz</u> ADDRESS <u>5209 York Road</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			
Seitz Funeral Home Balto. Md. 21212						DATE <u>JAN 10 1967</u>					

THE OFFICE OF THE

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MAILED 10/10/50
U.S. DEPT. OF JUSTICE
DIVISION OF INVESTIGATION
WASHINGTON, D.C.

00232

CERTIFICATE OF DEATH

00234

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stella Maris Hospice		d. STREET ADDRESS 3501 St. Paul Street	
NAME OF DECEASED (Type or print) Mary Agnes Coyne		4. DATE OF DEATH Month 1 Day 19 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH % 5/9/1888
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dir. of Claims Statistics Veterans Adm.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George W Wilkinson		14. MOTHER'S MAIDEN NAME Susan Winters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 215-32-8392	
17. INFORMANT Hospice records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Respiratory Failure Cerebral Vascular Hemorrhage ABCD		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar. 17, 1967 to Jan. 19, 1967 , that (I) (we) last saw the deceased alive on Jan. 18, 1967 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED 1/19/67	
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, MD		22d. ADDRESS 201 E. Joppa Rd., Towson	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/21/67	23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL	23d. LOCATION (City, town or county) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR'S SIGNATURE H.W. MEARS & SON 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR J. Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JAN 24 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00233

CERTIFICATE OF DEATH

00235

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 20yr8mth3dys.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1809 Linden Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lula Middle Crane Last Crane		4. DATE OF DEATH Month January Day 4 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1906
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME W.H. Wagner	
14. MOTHER'S MAIDEN NAME Disia Greene		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 18:30	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from May 1, 1965 to Jan. 4, 1967 , that (X) (we) last saw the deceased alive on Jan. 4, 1967 , and that death occurred at 18:30 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 1-4-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 1-5-67	23c. NAME OF CEMETERY OR CREMATORY Fernwood Cemetery	23d. LOCATION (City or Town) (County) (State) Delaware Co. Pa.
24. FUNERAL DIRECTOR Wm. J. Tibner & Son		25. REC'D BY REGISTRAR Balto., Md. north pa.	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE JAN 6 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEMERE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2510 SNYDER AVE		d. STREET ADDRESS 7929 LOVELL	
3. NAME OF DECEASED (Type or print) LOUISE E. CRIEKENBERGER		4. DATE OF DEATH Month JAN Day 18 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 4, 1917
9. AGE (In years lost birthday) 49 yrs.		10. BIRTHPLACE (State or foreign country) FLA.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME PETER EWING		14. MOTHER'S MAIDEN NAME ANN ALLSEBROOK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-38-4930	
17. INFORMANT EARL C. CRIEKENBERGER		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 525X IMMEDIATE CAUSE (a) Acute Pulmonary Failure DUE TO (b) Chronic Inflammatory disease of lung Etiology Undetermined (c) of lung		INTERVAL BETWEEN ONSET AND DEATH 8-10 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. C. FALLON		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) THRO. C. FALLON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 1/20/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/21/67	
23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J. E. CONNELLY SONS		ADDRESS 300 MACE	
25a. REC'D BY REGISTRAR J. Charles Judge		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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DATE

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00235

CERTIFICATE OF DEATH

00237

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shaker Heights 72.3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor, Seminary Ave.				d. STREET ADDRESS N. Moreland Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Anderson Cross				4. DATE OF DEATH Month Day Year January 6th., 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1882		9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Midland / Belleville, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred S. Anderson				14. MOTHER'S MAIDEN NAME Addie Sophia Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 300-40-8296		17. INFORMANT Frederic S. Cross, 900 1st Nat'l			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 congestive heart failure DUE TO (b) arteriosclerosis, generalized DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1/6 , 19 67 , to 1/6 , 19 67 , that (I) (we) last saw the deceased alive on 1/4 , 19 67 , and that death occurred at 8:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE William F. Fritz				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/6/67	
22c. PHYSICIAN'S NAME (Type) Dr. William F. Fritz				22d. ADDRESS 2 W. University Parkway			
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		23b. DATE THEREOF 1/7/1967		23c. NAME OF CEMETERY OR CREMATORY Knollwood		23d. LOCATION (City or Town) (County) (State) Mayfield Heights, Ohio	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR JAN 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00331

26508

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film G384 1/18/67 mh

00236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00238

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 1001 Reverdy Road	
3. NAME OF DECEASED (Type or print) PATRICIA ANN CROWTHER		4. DATE OF DEATH Month 1 Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1936
9. AGE (In years lost birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		12. KIND OF BUSINESS OR INDUSTRY Department Store	
13. BIRTHPLACE (State or foreign country) Baltimore, Md.		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Robert L. Crowther		16. MOTHER'S MAIDEN NAME Katheryn Wood	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 212-34-4293	
19. INFORMANT Robert L. Wood (Father)		Address Same	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 812.4 Multiple Traumatic Injuries DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Interval between onset and death			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Pedestrian struck by auto. Belvedere & Gilpin Ave.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. PM p.m. 1 11 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.		22. DATE SIGNED 1/11/67	
EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Eugenia K. Seitz		25a. REC'D BY REGISTRAR JAN 13 1967	
ADDRESS 5209 York Road Balto. Md. 21212		25b. REGISTRAR'S SIGNATURE Charles Judge	

00038

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00237

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00239

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 4 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balt.	
3. NAME OF DECEASED (Type or print) First Doris Middle Mary Last Cumberland		4. DATE OF DEATH Month Jan. Day 1 Year 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1924
9. AGE (In years lost, birthday) 42 yrs.		IF UNDER 1 YEAR Months 19 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Roger Cumberland		14. MOTHER'S MAIDEN NAME Rose Catherine Ubell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Records-Rosewood State Hosp.		Address Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxia (Due to aspiration of food) 9217 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) mental Retardation (Imbecile) DUE TO (c) none			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient rammed food in mouth + choked	
20c. TIME OF INJURY Month, Day, Year Hour 12:15 min. p.m. 1-1 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rosewood Hosp		20f. (City or town) (County) (State) Owings Mills Balt Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Catles		M.D.	
EXAMINER'S NAME (Type) D. D. CATLES		22. DATE SIGNED 1-1-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 4 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Brooklyn, A. A. Co. Md.	
24. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave	
25a. REC'D BY REGISTRAR JAN 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00333

UNITED STATES DEPARTMENT OF JUSTICE

RECORDS

00238

CERTIFICATE OF DEATH

00240

Item 2 Film G385 2/10/67

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB Months		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md		b. COUNTY 30-4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1209 Valley St. 1817 Munsey Bldg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First		Middle Cunningham		Last		4. DATE OF DEATH Jan. 26, 1967		Day		Year 19			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/27/ 1872		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Maid				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Rosecommon, Ireland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James A. Cunningham								14. MOTHER'S MAIDEN NAME Bridgett Boland							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-32-4200				17. INFORMANT Hospice records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Expiratory Arrest 4321 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Ascend DUE TO (c) Serious												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 19, 1954 to 1/27/67 , 19..., that (I) (we) last saw the deceased alive on 1/24/67 , 19..., and that death occurred at 2:00 PM from the causes and on the date stated above.															
22a. SIGNATURE Robert J. Mahon, MD								M.D.				22b. DATE SIGNED 1/26/67			
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, MD								22d. ADDRESS 204 E. Joppa Rd., Towson							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-28, 67				23c. NAME OF CEMETERY OR CREMATORY New Cathedral				23d. LOCATION (City, town or county) (State) Baltimore Baltimore, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Brooks Towson, Towson, Md. 21204								25a. REC'D BY REGISTRAR JAN 30 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00320

CERTIFICATE OF DEATH

1934

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00239

CERTIFICATE OF DEATH

00241

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 23yr6nth29dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3921 Yolando Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Curry				4. DATE OF DEATH Month Day Year January 31 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1877		9. AGE (In years last birthday) yrs. 89	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Kohler				14. MOTHER'S MAIDEN NAME Elizabeth Kunigunda			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-54-3083		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from July 2, 1943 to Jan. 31, 1967 , that (A) (we) last saw the deceased alive on Jan. 31, 19 67 and that death occurred at 2:00 p.m. , from causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-1-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 3 1967		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM		23d. LOCATION (City or Town) (County) (State) OLD FREDERICK RD MD	
24. FUNERAL DIRECTOR Duffel Bros Inc 1800 E LOMBARD ST				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

EASO

03200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00240					00242									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)										
Rural - Baltimore Highlands				Rural - Baltimore Highlands										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS									
2926 Ohio Avenue					2927 Georgia Avenue									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Helen Middle M. Last Dallas					Month January Day 30th Year 1967									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		February 9, 1918		48 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Seamstress				Howard Uniform Co.		Maryland		U. S. A.						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Louis Weber					Agnes Wisniewski									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No					218-01-8727					Walter T. Dallas - 2927 Georgia Avenue #21227				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Adenocarcinoma of colon				
1538										1 year				
Conditions, if any, which gave rise to immediate cause (b)														
(e), stating the underlying cause last.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19														
21. I certify that (I) (this hospital) attended the deceased from 11 Feb 1967 to 30 Jan 1967 , that (I) (we) last saw the deceased alive on 26 Jan 1967 , and that death occurred at 6:50 a.m. from the causes and on the date stated above.														
22a. SIGNATURE					22b. DATE SIGNED									
Wm. K. Gallagher, Jr.					30 Jan 67									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
Wilmer K. Gallagher Jr. M.D.					6630 BALTIMORE NAT. PIKE 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			Feb. 2, 1967		Lorraine Park Cemetery			Baltimore, Maryland						
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
George A. Weber					FEB 1 1967					John J. Judge				
ADDRESS George A. Weber - 705 South Ann St. #21231					DATE FEB 1 1967									

MEDICAL CERTIFICATION

per Ted Weber

00242

CERTIFICATE OF DEATH

00240

John - 1910-1911

John - 1910-1911

John - 1910-1911

John - 1910-1911

John - 1910-1911

John - 1910-1911

John - 1910-1911

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John - 1910-1911

John - 1910-1911

00241

CERTIFICATE OF DEATH

00243

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>12 MOS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSP.</u>		d. STREET ADDRESS <u>2221 W. EXINGTON ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUISA</u> Middle <u>DANIEL</u> Last <u>DANIEL</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NEURO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/79</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIS BOYD</u>		14. MOTHER'S MAIDEN NAME <u>RENNIE -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORD</u>	
17. INFORMANT <u>HOSPITAL RECORD</u>		Address <u>SGS.H.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO (b) <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE EXCEPT SENILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-31</u> , 19 <u>65</u> , to <u>Jan. 1</u> , 19 <u>67</u> , that <u>XX</u> (we) last saw the deceased alive on <u>January 1</u> , 19 <u>67</u> , and that death occurred at <u>7:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Allen W. Lane</u>		22b. DATE SIGNED <u>January 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Allen W. Lane</u>		22d. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Grenville N.C.</u>
24. FUNERAL DIRECTOR <u>Geo. G. Kelson 1348 n. Calhoun st.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>			

00349

RECEIVED

00349

Indonesian State National

Indonesian State National

00242

CERTIFICATE OF DEATH

00244

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WILLIAM DAVIS		4. DATE OF DEATH Month Day Year JANUARY 9 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1907
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) JERSEY CITY, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME <i>Joseph Davis</i>		14. MOTHER'S MAIDEN NAME <i>Julia Lambert</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217 01 84 74	
17. INFORMATION VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CHRONIC PYELONEPHRITIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN 5 , 19 67 , to JAN 9 , 1967, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JAN 9 , 19 67 , and that death occurred at 655P M, from causes and on the date stated above.			
22a. SIGNATURE <i>J. D. Talbert</i>		22b. DATE SIGNED 1/10/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-13-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR RAYNER SANDERS FUNERAL HOME		25a. REC'D BY REGISTRAR DATE JAN 16 1967	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00368

00368

RECORDS OF DEATH

DATE	TIME	PLACE	NAME	AGE	SEX	RACE	RELIGION	EDUCATION	OCCUPATION	CAUSE OF DEATH	DATE OF BURIAL	PLACE OF BURIAL
1900	10:00	St. Mary's	John D. Smith	45	M	White	Catholic	High School	Farmer	Heart Disease	1900	St. Mary's
1901	11:00	St. Mary's	John D. Smith	46	M	White	Catholic	High School	Farmer	Heart Disease	1901	St. Mary's
1902	12:00	St. Mary's	John D. Smith	47	M	White	Catholic	High School	Farmer	Heart Disease	1902	St. Mary's
1903	13:00	St. Mary's	John D. Smith	48	M	White	Catholic	High School	Farmer	Heart Disease	1903	St. Mary's
1904	14:00	St. Mary's	John D. Smith	49	M	White	Catholic	High School	Farmer	Heart Disease	1904	St. Mary's
1905	15:00	St. Mary's	John D. Smith	50	M	White	Catholic	High School	Farmer	Heart Disease	1905	St. Mary's
1906	16:00	St. Mary's	John D. Smith	51	M	White	Catholic	High School	Farmer	Heart Disease	1906	St. Mary's
1907	17:00	St. Mary's	John D. Smith	52	M	White	Catholic	High School	Farmer	Heart Disease	1907	St. Mary's
1908	18:00	St. Mary's	John D. Smith	53	M	White	Catholic	High School	Farmer	Heart Disease	1908	St. Mary's
1909	19:00	St. Mary's	John D. Smith	54	M	White	Catholic	High School	Farmer	Heart Disease	1909	St. Mary's
1910	20:00	St. Mary's	John D. Smith	55	M	White	Catholic	High School	Farmer	Heart Disease	1910	St. Mary's

00368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00243						00245							
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY Baltimore County						a. STATE Maryland							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson						b. COUNTY Balt. Co							
c. LENGTH OF STAY IN 1b 113 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balt. md. 21222 13.1							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital						d. STREET ADDRESS 3416 Mc Shane Way							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH							
First Middle Last Mary Campbell Davis						Month Day Year Jan 12 1967							
5. SEX F		6. COLOR OF RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-1891		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W f.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Campbell						14. MOTHER'S MAIDEN NAME Sarah Watson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 218-14-0449							
17. INFORMANT Records, Mt. Wilson State Hospital						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1561 Reticular Cell Sarcoma of Liver DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9-21- , 19 66 , to 1-12 , 19 67 , that (I) (we) last saw the deceased alive on 1-2 , 19 67 , and that death occurred at 12:50 PM, from the causes and on the date stated above.													
22a. SIGNATURE W. Newcomer						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-12-67					
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent						22d. ADDRESS Mount Wilson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1/16/67		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL		23d. LOCATION (City, town or county) (State) BALTIMORE, MD					
24. FUNERAL DIRECTOR Wm. Birchley Bradley, Inc.						ADDRESS 1111 N. Broadway, Baltimore, Md.		25. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

00345

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Mary

W

F

H.W.F.

George Campbell

No

218-14-000 Records, Mt. Wilson State Hospital

Sarah Watson

Pennsylvania

9-10-1901 22

Campbell Davis

2410 Mc Shaney

113 days

Washington

00345

Inspector, H.D., Superintendent

Mount Wilson, Maryland

Private 11/11/1901

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00244

00246

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Rural</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore rural</u> 13.1			
c. LENGTH OF STAY IN TB <u>5 yrs.</u>				d. STREET ADDRESS <u>1721 Aberdeen Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1721 Aberdeen Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(SAMUEL) First Middle Last</u> <u>SALVATORE Columbus Dell'Acqua</u>				4. DATE OF DEATH <u>Jan 5 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-18-32</u>	
9. AGE in years (last birthday) <u>35</u>		IF UNDER 1 YEAR Months <u>34</u> Days <u>34</u>		IF UNDER 24 HRS. Hours <u>34</u> Min. <u>34</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Loch Raven Village Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LUCIANO Dell'Acqua</u>				14. MOTHER'S MAIDEN NAME <u>Angela ONORATO</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1949 - 1952</u>				16. SOCIAL SECURITY NO. <u>214-26-6461</u>			
17. INFORMANT <u>Anna Dell'Acqua</u>				Address <u>Dell'Acqua</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiac Vascular Disease - Coronary Insufficiency</u> DUE TO (b) <u>several yrs.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>several yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John C. H. Lee</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN C. H. Lee</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Jan 5 - 67</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 10 1967</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00340

00340

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00245					00247						
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>			d. STREET ADDRESS <u>ROUTE 4 BOX 123A</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>DEMBY, MAY NEVELLA</u>		First Middle Last <u>DEMBY</u>		4. DATE OF DEATH <u>1</u> Month <u>19</u> Day <u>67</u> Year <u>10:55 AM</u>		5. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/13/07</u>		9. AGE (In years last birthday) <u>59</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JAMES FRANKLIN</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Boose</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest Demby, 1275 Kitmore Rd.</u>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN ABSCESS</u> 3912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OTITIS MEDIA</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS WITH RENAL FAILURE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u> <u>10 DAYS</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>January 18, 1967</u> , to <u>January 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 19, 1967</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dora C. Kuwilsky</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1-19-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dora C. Kuwilsky</u>					22d. ADDRESS <u>Greater Baltimore Medical Center</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>					25a. REC'D BY REGISTRAR <u>JAN 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

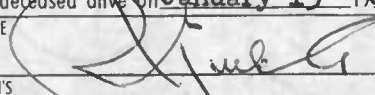
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

00246

CERTIFICATE OF DEATH

00248

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 13.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21221 d. STREET ADDRESS 10 Marie Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lerew William Detter		4. DATE OF DEATH Month January Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1914 9. AGE (In years last birthday) yrs. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fidelity Ship Celing		11. BIRTHPLACE (County & State, or foreign country) Baltimore	
13. FATHER'S NAME GEO. DETTER		14. MOTHER'S MAIDEN NAME ETHEL LEREW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK		16. SOCIAL SECURITY NO. 189-07-2686	
17. INFORMANT MYRTLE DETTER		Address 10 MARIE AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinomatosis, primary site undetermined. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Partial intestinal obstruction 2. Gastro-jejunal dilatation			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from December 21, 1966 , to January 15 1967 , that (X) (we) last saw the deceased alive on January 15 1967 , and that death occurred at 7:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED January 15, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Road, Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/18/67	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION (City or Town) (County) (State) BALTO. MD.
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR 300 MACE	25b. REGISTRAR'S SIGNATURE Charles Judge

34500

22500

CERTIFICATE OF DEATH

00249

00247

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1723 Selma Avenue		d. STREET ADDRESS 1723 Selma Avenue	
3. NAME OF DECEASED (Type or print) LOT W. DISNEY		4. DATE OF DEATH Month January Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 19 Days 67 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Disney		14. MOTHER'S MAIDEN NAME Susann Warfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-8393	
17. INFORMANT Mrs. Hester D. Disney, 1723 Selma Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Cardio Vascular disease (b) Ischemic heart disease DUE TO Myocardial infarction (c) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 1 day 10 day 3 yro			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 13, 1967 , to Jan 15, 1967 , that (I) (we) last saw the deceased alive on Jan 13, 1967 , and that death occurred at 4:22 PM from causes and on the date stated above.			
22a. SIGNATURE Dr. Bruce Brumbaugh		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Bruce Brumbaugh		22d. ADDRESS 5609 Main Street, Elkridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-18-1967	23c. NAME OF CEMETERY OR CREMATORY Emmanuel Baust Cemetery	23d. LOCATION (City or Town) (County) (State) Westminster, Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE JAN 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

00249

00249

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

State of ...

Decedent's Name

Age

Place of Birth

Date of Death

Sex

Color

Height

Weight

Build

Education

Occupation

Marital Status

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

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VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00248											
00250											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before and during death) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>56 Greater Baltimore Medical Centre</u>						d. STREET ADDRESS <u>Charles & 31st Street.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIA KERR DOBBIN</u>						4. DATE OF DEATH Month Day Year <u>JANUARY 17 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Can.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Eastern Shore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>TILTON HEMSLEY</u>						14. MOTHER'S MAIDEN NAME <u>THOMAS.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-72-3467</u>		17. INFORMANT <u>PH's chart</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arterio-sclerotic vascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 13th</u> , 1967, to <u>Jan. 14th</u> , 1967, that (I) (we) last saw the deceased alive on <u>Jan. 17th</u> , 1967, and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>M. Isabelle MacGregor</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1-17-67.</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. ISABELLE MacGREGOR</u>						22d. ADDRESS <u>Greater Baltimore Medical Centre</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Episcopal Church</u>			23d. LOCATION (City, town or county) (State) <u>Elkridge Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins</u>						ADDRESS <u>7 Sons Co. 4905 York Rd., Balto</u>		25a. REC'D BY REGISTRAR <u>JAN 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

00248

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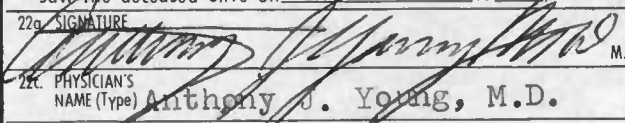

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00249

00251

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 8yrs. 27dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cornelia Middle Carneal Last Dorman		4. DATE OF DEATH Month January Day 30 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1875
9. AGE (In years last birthday) yrs. 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emilia Carneal Leland Carneal		14. MOTHER'S MAIDEN NAME Virginia Muellner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Generalized Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial pneumonia, organism unknown			
INTERVAL BETWEEN ONSET AND DEATH acute 40 yrs. 40 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. (this hospital) attended the deceased from Dec. 28 , 19 67 , to 19 , that (I) (we) lost saw the deceased alive on 1-30 , 19 67 , and that death occurred at 8 P M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 1/30/67 9:30	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) 3801 Frederick Ave. Balto., Md	
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR FEB 2 1967	
ADDRESS 4107 Wilkens Avenue 21229		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 mos 27 dy.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>30.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>2319 Annapolis Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GORDON</u> Middle <u>A</u> Last <u>EADES</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>12</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Meahlin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-6388</u>	
17. INFORMANT <u>Records: Spring Grove State Hosp.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>450.0</u> DUE TO <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis severe</u> (c) <u>Chronic Brain Syndrome & psychotic reaction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome & psychotic reaction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1965</u> to <u>1-14, 1967</u> that (I) (we) last saw the deceased alive on <u>1-14, 1967</u> , and that death occurred at <u>1:45 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D. Imte KOPITS, M.D.</u>		22b. DATE SIGNED <u>Jan-14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. Imte KOPITS, M.D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>	23d. LOCATION (City or Town) (County) (State) <u>GLEN DERNIE AA MD.</u>
24. FUNERAL DIRECTOR <u>MCCULLY FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>JAN 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

00325

CERTIFICATE OF DEATH

00325

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00251

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 31m 4305

1/23/67 mh

00251

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>209 E. Joppa Road</i>		d. STREET ADDRESS <i>209 E. Joppa Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Ernest</i> Middle <i>Anton</i> Last <i>Ecsery</i>		4. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 2, 1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chiropractor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	9. AGE (In years last birthday) <i>68</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Stephan Ecsery</i>		14. MOTHER'S MAIDEN NAME <i>Marie Brana</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Family Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> 154.X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma of Rectum</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1-16-</i> , 1967, to <i>1-16-</i> , 1967, that (I) (we) last saw the deceased alive on <i>1-16-</i> 1967, and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>M. X. Quinn</i>		22b. DATE SIGNED <i>1-20-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>M. KEVIN QUINN MD</i>		22d. ADDRESS <i>1927 York RD, TIMORUM, Balt. Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated</i>	23b. DATE THEREOF <i>Jan. 20, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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DEPARTMENT OF HEALTH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 4 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1813 East Ave.		d. STREET ADDRESS 1813 East Ave.	
3. NAME OF DECEASED (Type or print) Caroline		4. DATE OF DEATH Month January Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/85
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Arco Paint Co.	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ? Teffs		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 271-22-8787	
17. INFORMANT (Son) Edward Edelburg, 1813 East Ave. Dundalk Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) A-S-C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		22. DATE SIGNED 6800 Morning- 1/25/67	
EXAMINER'S NAME (Type) Melvin B. Davis		M. D. M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/67	
23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE JAN 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Exhibits

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00253

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00255

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. Gen. Hosp.		d. STREET ADDRESS 3407 Kimble Road	
3. NAME OF DECEASED (Type or print) Andrew B. Eickhoff		4. DATE OF DEATH Month Jan. Day 19 Year 19 67	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) yrs. 67
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Eickhoff		14. MOTHER'S MAIDEN NAME Ann Blumenstock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth L. Eickhoff, 3407 Kimble Rd., Balto.		Address 7, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o.m. none 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-23-1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave., Balto.		25a. REC'D BY REGISTRAR DATE JAN 24 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00254						00256					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3611 Delverne Rd. BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med Ctr</u>						d. STREET ADDRESS <u>3611 Delverne Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Annetta</u> Middle <u>(NIA)</u> Last <u>Ellison</u>						4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1967</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>Can</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-84</u>		9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>B.A. Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Calvert</u>						14. MOTHER'S MAIDEN NAME <u>Blunt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-058150</u>		17. INFORMANT <u>Patients Chart</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>5271</u> DUE TO <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>EMPHYSEMA WITH COR PULMONALE</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-23-</u> , 19 <u>67</u> , to <u>1-30-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-30-</u> , 19 <u>67</u> , and that death occurred at <u>11:40AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>E.K.S. Narayanan</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1-30-1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>EDATHIL K.S. NARAYANAN</u>						22d. ADDRESS <u>INTERN, GREATER BALTO. MED. CENTER - MD. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Magothy Meth. Church</u>				23d. LOCATION (City, town or county) (State) <u>AnneArundel Co. Md.</u>			
24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Road Balto. Md. 21212</u>						25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00324

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00255		00257	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 13.1	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		d. STREET ADDRESS 1010 St. Charles Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1007 St. Charles Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PETER C. ELLSTROM		4. DATE OF DEATH Month January Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilmaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustaf Ellstrom		14. MOTHER'S MAIDEN NAME Hilda Ellstrom	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Christine Douden, St. Petersburg, Fla.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Anti Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ASCUD (c)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 2 , 19 66 , to Jan 9 , 19 67 , that (I) (we) saw the deceased alive on Jan 6 , 19 67 , and that death occurred at 8 P.M. from causes and on the date stated above.			
22a. SIGNATURE Earl Pass		22b. DATE SIGNED 1-10-67	
22c. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass		22d. ADDRESS 4001 Wilkens Avenue, Balto. Md. 29	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE JAN 12 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

1M

00256

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00258

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PERRY HALL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY HALL			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9531 HORN AVE.				d. STREET ADDRESS 9531 HORN AVE. 31236			
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL. JOSEPH EWERS.				4. DATE OF DEATH Month Day Year JAN 25 1967.			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1891	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Edgewood Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Frederick Ewers			
14. MOTHER'S MAIDEN NAME Margaret O'Brien				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. 219-07-2579A				17. INFORMANT Address Mrs Mary E. Ewers 9531 Horn Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aortic Aneurysm DUE TO (b) Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH undet.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-25-67							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE JOAN P. Hyle		EXAMINER'S NAME (Type) JOAN P. Hyle		DATE SIGNED 1-25-67			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-28-1967		22c. NAME OF CEMETERY OR CREMATORY St/ Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Co. Md.	
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd.				24. REC'D BY REGISTRAR DATE JAN 30 1967			
24b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

00258

00258



9201 Horn Ave
Peters Hall

9201 Horn Ave
Peters Hall

Carroll Joseph

Carroll Joseph

U.S.A.

encl.
encl.

Attorney General
Department of Justice

1-26-61

John F. Kennedy
John F. Kennedy

John F. Kennedy
John F. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00257					00259				
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE 15.2 d. STREET ADDRESS 1300 VANDALIA DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSEPHINE MARTHA FARRAR			4. DATE OF DEATH Month 1 Day 12 Year 1966						
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/28	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHESTER SHELLMAN				14. MOTHER'S MAIDEN NAME CLEO SHRECK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 515-14-248		17. INFORMANT Address Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 CHRONIC OBSTRUCTIVE PULMONARY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. EMPHYSEMA (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from 12/12, 1966 , to 1/12, 1967 , that (1) (we) last saw the deceased alive on 1/12, 1966 , and that death occurred at 1:20 PM , from the causes and on the date stated above.									
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 1/12/68		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22d. ADDRESS Mount Wilson, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/17/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR DATE JAN 16 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			

00253

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

Mr. Lawrence, M.D., Superintendent, Mount Wilson, Maryland

Mount Wilson State Hospital

Rockville, Md.

00258

CERTIFICATE OF DEATH

00260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Then~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 13.1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 513 Back River Neck Rd.	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Clara Last FERSTERMANN		4. DATE OF DEATH Month January Day 6 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1897	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 6 Days 13 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles Hahn		
14. MOTHER'S MAIDEN NAME Clara Ahrens			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Richard Ferstermann Address 513 Nack River Neck Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 576X IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Thrombo-Embolus					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that AK (this hospital) attended the deceased from 12/29/ , 19 66 , to 1/6/ , 19 67 , that OK (we) last saw the deceased alive on 1/6/ , 19 67 , and that death occurred at 12 A.M. from causes and on the date stated above.					
22a. SIGNATURE Reymaldo Orjuela - Gomez			22b. DATE SIGNED 1/6/67		
22c. PHYSICIAN'S NAME (Type) Dr. J. M. D.			22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/9/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.			25a. REC'D BY REGISTRAR DATE JAN 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

4350

1972

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00259					00261				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY		BALTIMORE			a. STATE		MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTIMORE (Rural)			b. COUNTY		BALTIMORE		
c. LENGTH OF STAY IN 1b		10 days			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		BALTIMORE #18		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
GREATER BALTIMORE Medical Center					1607 E 29th STREET		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
			CHARLOTTE CATHERINE FINGLES				1 10 1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		APRIL 13, 1916		70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife						BALTIMORE, Md		BALTIMORE	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
ANTHONY JOSEPH WALKER					HUGHES, Mary Hulse				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			213-03-6742		Thomas J Fingles		Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY THROMBOEMBOLISM									
200.2									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALIGNANT LYMPHOMA									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1-2, 1967 to 1-10, 1967 that (I) (we) later saw the deceased alive on 1-10, 1967, and that death occurred at 10:50 P.M. from the causes and on the date stated above.									
22a. SIGNATURE									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)									
22d. ADDRESS									
22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE THEREOF									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									

Burial 1/14/67 Parkwood Baltimore Md.
L. J. Ruck Inc 5305 Harford Rd. JAN 13 1967 Charles Judge

00358

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(1941)

April 13

Memphis

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

REURTEL, APRIL TWELVE LAST.

REURTEL, APRIL TWELVE LAST.

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200

Wm. A. Rorer

Very truly yours,
Wm. A. Rorer

Wm. A. Rorer, Jr., President, Southern Railway System, Inc.

00260

CERTIFICATE OF DEATH

00262

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>2709 Oakley Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry Finkelstein</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unk</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-07-5750A</u>	
17. INFORMANT <u>Nursing Home Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>40 yrs</u> (c) <u>Arteriosclerotic Cardiovascular Dis</u> <u>40 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>66</u> , to <u>1/13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1/13</u> 19 <u>67</u> and that death occurred at <u>8:15 AM</u> , from causes on and the date stated above.			
22a. SIGNATURE <u>David E. Zickafoose</u> M.D.		22b. DATE SIGNED <u>1/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickafoose, M.D.</u>		22d. ADDRESS <u>445 W. Lane, Elliott City, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-15-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOBEOSKER BENEFICIAL</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Salvatore Bros. Inc. Dist. Co.</u>		25a. REC'D BY REGISTRAR <u>6010</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 20 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00263											
1. PLACE OF DEATH a. COUNTY <u>Baltimore.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton. 13.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulaney-Towson Conv. Home.</u>						d. STREET ADDRESS <u>Monkton Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Edgar</u> Last <u>Fishel</u>						4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegrapher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stewartstown, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Fishel</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>717-07-7908</u>		17. INFORMANT <u>Mrs. Mahel Fishel, Monkton, Md. 21111.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left kidney</u> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1966</u> , to <u>Jan 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 22, 1967</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Loy M. Zimmerman</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 22, 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman MD.</u>						22d. ADDRESS <u>3202 Hartford Rd. Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Lutheran</u>			23d. LOCATION (City, town or county) (State) <u>Shrewsbury Penna.</u>			
24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>						ADDRESS <u>New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
						DATE <u>JAN 25 1967</u>					

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[illegible]

Delaney-Townsend Court House

Clarence Edgar

W M

Daniel Fisher

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Margaret M.

John M. L. Foster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00262											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>6 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				30.4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						d. STREET ADDRESS <u>3939 Toland Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>L.</u> Last <u>Fitzell</u>			4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-17-38</u>			9. AGE (In years last birthday) <u>83</u> yrs.			IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>William R. Lynch</u>						14. MOTHER'S MAIDEN NAME <u>GRACE, Sara</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. T. R. Fitzell</u>				Address <u>3023 Duglow Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial injury, probably infarction</u> DUE TO (c) <u>Coronary disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1967</u> , to <u>January 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 15, 1967</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dora C. Kuwilsky</u> 22b. DATE SIGNED <u>1-16-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>Dora C. Kuwilsky</u>						22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/19/1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore County, Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. J. Fink & Son</u>						25a. REC'D BY REGISTRAR <u>JAN 17 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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FOR STATE
HEALTH DEPT

00263

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00265

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO - rural Parkville 3mos c. LENGTH OF STAY IN 1b 3mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8515-D Old Harford				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO - rural - Parkville 03.1 d. STREET ADDRESS 8515-D Old Harford 34 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alice First Ida Middle Fletcher Last				4. DATE OF DEATH January 1 19 67 Month January Day 1 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-17-1912	
9. AGE in years (last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Hanover Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-22-854		17. INFORMANT Frederick Fletcher Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH undet	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John C. Hyle		EXAMINER'S NAME (Type) JOHN C. Hyle		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1 Jan 67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-4-67		23c. NAME OF CEMETERY OR CREMATORY Garden of Faith		23d. LOCATION (City, town or county) (State) BALTO MD	
24. FUNERAL DIRECTOR CHAR. F. EVANS		ADDRESS 8802 Harford Rd		25a. REC'D BY REGISTRAR 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

00264

CERTIFICATE OF DEATH

00266

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr6mth28dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville, Maryland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 149A Church Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Fletcher		4. DATE OF DEATH Month 1-12-67 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 67 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Records: Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 6-14-63 , 19 63 , to 1-12 , 19 67 that (we) lost saw the deceased alive on 1-12-67 19 67 , and that death occurred at 9:12 A.M. from causes and on the date stated above.			
22a. SIGNATURE Narcisco Carmona M.D. M.D.		22b. DATE SIGNED 1-12-67	
22c. PHYSICIAN'S NAME (Type) Narcisco, Carmona, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-17-67	23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery	23d. LOCATION (City or Town) (County) (State) Landover, Md.
24. FUNERAL DIRECTOR Rollins Fun Home 4339 Hunt Pl NE		25a. REC'D BY REGISTRAR DATE JAN 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00388

TESTIMONY OF EIGHT

00388

Witnesses: [illegible]

Witnesses: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

Item 230 Film G705 2/5/67 mh

00265

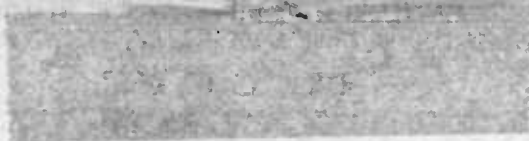
CERTIFICATE OF DEATH

00267

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 48 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNERS STATION 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 520 NORTH PITTSBURGH AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle C Last FOSTER			4. DATE OF DEATH Month JANUARY Day 29 Year 19 67		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1920		9. AGE (In years (last birthday) yrs. 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEELWORKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CLARKE COUNTY, GEORGIA	
13. FATHER'S NAME WILL HENRY FOSTER			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-11			16. SOCIAL SECURITY NO. 260 12 6277		
17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS ADVANCED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS, CEREBRAL ARTERIOSCLEROSIS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from DEC. 12, 1966 , to JAN. 29, 1967 , that (X) (we) last saw the deceased alive on JAN. 29, 1967 , and that death occurred at 1:30 P. M, from causes and on the date stated above.					
22a. SIGNATURE <i>W. J. Hahn</i>		ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/29/67	
22c. PHYSICIAN'S NAME (Type) WON JU HAHN, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/2/1967		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND	
23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Morton & Dyett 1701 Laurens St. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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00268

CERTIFICATE OF DEATH

00268

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOREST HAVEN NURSING HOME		d. STREET ADDRESS 5514 Heatherwood Rd	
3. NAME OF DECEASED (Type or print) Joseph HENRY FULLER		4. DATE OF DEATH Month JAN. Day 12 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1891
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 1 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Joseph Fuller		14. MOTHER'S MAIDEN NAME ANNA STOLZENBACH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MINNIE WALL		Address 5514 Heatherwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE ISCHEMIC CARDIOVASCULAR DUE TO (b) DISEASE - CEREBROVASCULAR DUE TO (c) ACCIDENT & ARTERIOVENOUS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 67 , to 1/14 , 19 67 , that (I) (we) last saw the deceased alive on 1/11 , 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above			
22a. SIGNATURE John H. Shaw M.D.		22b. DATE SIGNED 1/13/67	
22c. PHYSICIAN'S NAME (Type) John H. Shaw		22d. ADDRESS 5801 EMBURY RD BALTO. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORY LORRAINE PK. Cem	23d. LOCATION (City or Town) (County) (State) BALTO. Md.
24. FUNERAL DIRECTOR E. S. Mac Nabbs		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If the deceased is to be buried, the funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

00568

STATE OF TEXAS

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00267

CERTIFICATE OF DEATH

00269

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home		d. STREET ADDRESS 4603 Manordenne Road	
3. NAME OF DECEASED (Type or print) CLARENCE E. GANNON		4. DATE OF DEATH January 22, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1875
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 216-05-7494		17. INFORMANT Mrs. Elizabeth C. Reed, 4603 Manordene Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary atherosclerosis DUE TO (c) Diabetic mellitus		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967 to 1/22 1967 , that (I) (we) lost saw the deceased alive on 1/15 1967 and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff		22b. DATE SIGNED 1/23/67	
22c. PHYSICIAN'S NAME (Type) Dr. Cliff Ratliff, Jr.		22d. ADDRESS 4605 Edmondson Avenue, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-24-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR DATE JAN 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED OF DEATH

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NAME OF DECEASED		DATE OF DEATH	
RESIDENCE		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		SOURCES OF INCOME	
FAMILY HISTORY		SOCIAL HISTORY	
PSYCHOLOGICAL HISTORY		SUBSTANCE USE	
MENTAL STATUS		PHYSICAL STATUS	
LABORATORY TESTS		IMMUNIZATION	
TREATMENT		PROGNOSIS	
FOLLOW-UP		DISPOSITION	

RECEIVED
DATE
TIME
BY
OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00268					00270				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Baltimore		Jawson			md 21117		Baltimore		
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
		Dulaney-Jawson Nursing Home			Owings Mills		Caveswood Lane		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
William A Gaynor					1 23 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 81 yrs.	
Male		white							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Shoe manufacturing			Shoes			Baltimore		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Meyer Goldberg					Ida ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
No			217-01-9667		Mr. Emanuel A. Gaynor,			Owings Mills, Caveswood Lane,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Bronchopneumonia								2 days	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO (c) Severe general & cerebral arteriosclerosis								2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from Aug 1966, to Jan 23, 1967, that (I) (we) last saw the deceased alive on Jan 19 1967, and that death occurred at 7:15 M, from the causes and on the date stated above.									
22a. SIGNATURE						22b. DATE SIGNED			
James E. Cohen						1/23/67			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
						6702 Park Heights Ave. BALTO. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			1/25/67		Hebrew Friendship		Baltimore, Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sal Levinson & Bros. Inc., 6010 Reisterstown						JAN 30 1967		J Charles Judge	

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00269

CERTIFICATE OF DEATH

00271

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington		c. LENGTH OF STAY IN lb 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Pimlico Road		d. STREET ADDRESS Old Pimlico Road	
3. NAME OF DECEASED (Type or print) WALTER T. GEARY		4. DATE OF DEATH Month January Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1883
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meats	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Geary		14. MOTHER'S MAIDEN NAME Mary O'Day	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-32-3829	
17. INFORMANT Howard W. Geary		Address Old Pimlico Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Atherosclerosis, generalized DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 Jan , 1967, that (I) (we) last saw the deceased alive on Jan 9, 1967 , and that death occurred at 1P M. from causes and on the date stated above			
22a. SIGNATURE William G. Helfrich		22b. DATE SIGNED 1-10-67	
22c. PHYSICIAN'S NAME (Type) William G. Helfrich, M.D.		22d. ADDRESS 5006 Roland av. Balto Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/13/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR JAN 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00270

CERTIFICATE OF DEATH

00272

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto County General Hosp.</u>		d. STREET ADDRESS <u>4114 Northern Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>BENjamin</u> Middle <u>S</u> Last <u>GETTINGS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Self Employed Poultry</u>		9. AGE (In years last birthday) <u>64</u> yrs.	11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Va.</u>
13. FATHER'S NAME <u>William H. Gettings Sr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>218-14-3947</u>	
17. INFORMANT <u>Mr. William H. Gettings Jr.</u>		Address <u>5402 Clover Rd. 21215</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Julianus血症 acute</u> DUE TO (c) <u>old myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u> <u>3 hrs.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>67</u> , to <u>1-3</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1-3</u> , 19 <u>66</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gluck / Dr. Joy</u>		22b. DATE SIGNED <u>1/3/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Balto. County Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md. 21208</u>
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00343

CERTIFICATE OF DEATH

Reg. Dist. No.

00273

00271

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>Baltimore - 7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines - Catonsville, Md.</u>				d. STREET ADDRESS <u>1451 Langford Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Hayden</u> Middle <u>P.</u> Last <u>Gill</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22/92</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>25</u> Hours <u>10</u> Min. <u>31</u>	IF UNDER 24 HRS. Months <u>12</u> Days <u>25</u> Hours <u>10</u> Min. <u>31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gill</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-07-5842 A</u>		INFORMANT <u>Mrs. Hayden P. Gill</u> <u>1451 Langford Rd.</u>		Address <u>- #7</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12mo</u> <u>1031</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-14</u> , 19 <u>65</u> , to <u>1-17</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>67</u> , and that death occurred at <u>6:15 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1/19/67</u>							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher Sr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, Sr. - 6209 Frederick Ave. Balt. 21228 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-20-67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F. D. - 4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00272

CERTIFICATE OF DEATH

00274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		d. STREET ADDRESS 1305 - Wildwood Parkway	
3. NAME OF DECEASED (Type or print) MARY GOHEEN		4. DATE OF DEATH Month January Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/1879
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Roderick		14. MOTHER'S MAIDEN NAME Harriot Gibson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Miss Mildred Goheen (above address)	
17. INFORMANT Miss Mildred Goheen (above address)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO General Arterio Sclerosis (b) Diabetes Mellitus (c) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1959 , 19 Jan 11 , 19 67 that (I) (we) last saw the deceased alive on Jan 11 19 67 , and that death occurred at 3 P.M. from causes and on the date stated above.			
22a. SIGNATURE Samuel P. Alagia M.D.		22b. DATE SIGNED 1/12/67	
22c. PHYSICIAN'S NAME (Type) Dr. D.P. Alagia		22d. ADDRESS 305 Frederick Ave, Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Wash. D.C.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25. REC'D BY REGISTRAR Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00273

CERTIFICATE OF DEATH

00275

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3131 Acton Road		d. STREET ADDRESS 3131 Acton Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle H. Last Good		4. DATE OF DEATH Month January Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1904
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.	11. BIRTHPLACE (County & State, or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Good	
14. MOTHER'S MAIDEN NAME Josephine McGinnes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. 213-07-0300		17. INFORMANT Mrs. Edna D. Good Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes mellitus DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19 —	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 19 42 to Jan 11 1967 , that (I) (we) last saw the deceased alive on Jan. 10 1967 , and that death occurred at 11:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. M. Bacon		22b. DATE SIGNED 1/12/67	
22c. PHYSICIAN'S NAME (Type) A. M. BACON		22d. ADDRESS 2810 Taylor Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 1/16/67.	23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. # 21214		25a. REC'D BY REGISTRAR JAN 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00215

DEPARTMENT OF DEATH

00215

Name of Deceased		Date of Death	
John Doe		January 15, 1900	
Place of Death		City of Baltimore	
Cause of Death		Died of natural causes	
Age at Death		65 years	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		None	
Residence at Death		123 Main Street, Baltimore, Md.	
Burial Place		Catholic Cemetery, Baltimore, Md.	
Funeral Expenses		\$100.00	
Signature of Registrar		[Signature]	
Signature of Deceased		[Signature]	

FOR STATE
HEALTH DEPT.

00274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00276

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stewartstown 75.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore - Harrisburg Expressway		d. STREET ADDRESS Mill Street	
3. NAME OF DECEASED (Type or print) WILLIAM C. GRAFTON		4. DATE OF DEATH (Found) Month January Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1900 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Grafton		14. MOTHER'S MAIDEN NAME Elizabeth Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-22-0032	
17. INFORMANT Mary E. Grafton		Address Mill Street Stewartstown, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty M.D.		22. DATE SIGNED 1/24/67	
EXAMINER'S NAME (Type) Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/26/1967	23c. NAME OF CEMETERY OR CREMATORY William Watters	23d. LOCATION (City or Town) (County) (State) Cooptown Harford Md.
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00336

00336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00275					00277				
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>03.1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>504 Alleghany Avenue</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>504 Alleghany Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Muriel</u> Middle <u>S.</u> Last <u>Powers Grason</u>					4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 6, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W.H. Powers</u>					14. MOTHER'S MAIDEN NAME <u>Louisa Sheffley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Family records</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>APP. 2 WKS</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>March 24, 1955</u> to <u>JAN 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 24, 1967</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>T. C. Siwinski</u>					22b. DATE SIGNED <u>Jan. 26, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u>					22d. ADDRESS <u>206 W. Pennsylvania Ave., Towson, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Towson, Md. 21204</u>		
24. FUNERAL DIRECTOR <u>John Burns Sons 610-12 York Road Towson</u>					25a. REC'D BY REGISTRAR <u>JAN 31 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

CS-1

• **English** •

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00276

CERTIFICATE OF DEATH

00278

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u>				c. LENGTH OF STAY IN lb <u>9mo + 5days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>				d. STREET ADDRESS <u>726 HOWARD RD</u>			
3. NAME OF DECEASED (Type or print) <u>Sophia</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1892</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>ROSEWELL W GRAVES</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA L WYATT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mr. Arthur R. Wyatt, 1510 N. Mount Ave. Md.</u>				Address <u>Baltimore 21204</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral vascular accident & rt hemiplegia</u>							
DUE TO <u>331X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>4 Jan., 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3 Jan. 1967</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.							
22e. SIGNATURE <u>Paul Royce</u>				M.D.		22b. DATE SIGNED <u>Jan 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul L Royce</u>				22d. ADDRESS <u>1403 Foley Ln Pikesville Md 21208</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jan 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Thomas Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Garrison, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank R. Howell</u>				25e. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>Pikesville Md</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00238

CENTRAL OF DEATH

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00277

Item 2 Film G385 2/8/67 mh

CERTIFICATE OF DEATH

00279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>New York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor Nursing Home</u>		d. STREET ADDRESS <u>11 Waverly Place</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u>		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse - self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	9. AGE (In years last birthday) yrs. <u>89</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amasie Dunlap</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>120-18-3881</u>	
17. INFORMANT <u>Mr. H. Thompson Bousee</u>		Address <u>4416 Underwood Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>61</u> , to <u>1/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William F. Fritz</u>		22b. DATE SIGNED <u>1/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Fritz, M.D.</u>		22d. ADDRESS <u>2 West University Pkwy, Balto. 21218</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>William J. Zickner + Sons North + Pennsylvania</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

00518

00518

00518

1. NAME OF THE PARTY		2. ADDRESS	
3. OCCUPATION		4. DATE OF BIRTH	
5. SEX		6. MARITAL STATUS	
7. EDUCATION		8. RELIGION	
9. ETHNICITY		10. NATIONALITY	
11. PLACE OF BIRTH		12. DATE OF ENTRY	
13. REASON FOR ENTRY		14. CURRENT STATUS	
15. SIGNATURE		16. OFFICIAL USE	
17. DATE		18. OFFICIAL USE	
19. OFFICIAL USE		20. OFFICIAL USE	
21. OFFICIAL USE		22. OFFICIAL USE	
23. OFFICIAL USE		24. OFFICIAL USE	
25. OFFICIAL USE		26. OFFICIAL USE	
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33. OFFICIAL USE		34. OFFICIAL USE	
35. OFFICIAL USE		36. OFFICIAL USE	
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39. OFFICIAL USE		40. OFFICIAL USE	
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53. OFFICIAL USE		54. OFFICIAL USE	
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59. OFFICIAL USE		60. OFFICIAL USE	
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65. OFFICIAL USE		66. OFFICIAL USE	
67. OFFICIAL USE		68. OFFICIAL USE	
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89. OFFICIAL USE		90. OFFICIAL USE	
91. OFFICIAL USE		92. OFFICIAL USE	
93. OFFICIAL USE		94. OFFICIAL USE	
95. OFFICIAL USE		96. OFFICIAL USE	
97. OFFICIAL USE		98. OFFICIAL USE	
99. OFFICIAL USE		100. OFFICIAL USE	

RECEIVED
OFFICE OF THE
DIRECTOR
IMMIGRATION
AND
NATURALIZATION
SERVICE
U.S. DEPARTMENT OF
JUSTICE
WASHINGTON, D.C.
JAN 10 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
00278		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 61 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle WILLIAM Last GRAY		4. DATE OF DEATH Month JANUARY Day 11 Year 1967	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 29, 1914	
9. AGE (In years last birthday) yrs. 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
11. BIRTHPLACE (County & State, or foreign country) LOTHIAN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE GRAY		14. MOTHER'S MAIDEN NAME MARY WHITTINGTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218 12 90 37	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LUNG WITH METASTASIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/11/66 , 19____, to 1/11/67 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/11/67 , 19____, and that death occurred at 9:00PM , from causes and on the date stated above.		22a. SIGNATURE Peter Juvan M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22b. DATE SIGNED 1/12/67		22c. PHYSICIAN'S NAME (Type) PETER JUVAN, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 1-15-1967		23c. NAME OF CEMETERY OR CREMATORY LOTHIAN CEMETERY	
23d. LOCATION (City or Town) (County) (State) LOTHIAN, MARYLAND		24. FUNERAL DIRECTOR William Reesett ADDRESS REESE FUNERAL HOME WASHINGTON ST. ANNAPOLIS, MD.	
25a. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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CLAYTON K. MILES

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00279

CERTIFICATE OF DEATH

00281

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2707 Gwynnmore Avenue		d. STREET ADDRESS 2707 Gwynnmore Avenue	
3. NAME OF DECEASED (Type or print) Charles Edward Grewe		4. DATE OF DEATH Month January Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1899
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Specialist	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Grewe	
14. MOTHER'S MAIDEN NAME Elizabeth		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 216-03-4259		17. INFORMANT Muriel O. Grewe 2707 Gwynnmore Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 165X Metastatic Carcinoma of Lung At. 14 yrs. IMMEDIATE CAUSE (a) DUE TO Chronic Sclerotic Heart Disease - 2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Nov. 17 , 19 66 , to Jan 26 , 19 67 , that (I) (was) last saw the deceased alive on 1/26 , 19 67 , and that death occurred at 7 P. M, from causes and on the date stated above.	
22a. SIGNATURE Earl L. Chambers		22b. DATE SIGNED 1/27/67	
22c. PHYSICIAN'S NAME (Type) Earl L. Chambers		22d. ADDRESS 4108 Liberty Sts Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-30-1967	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Ellsworth Amaco		25a. REC'D BY REGISTRAR DATE JAN 30 1967	
25b. REGISTRAR'S SIGNATURE William Judge		25c. ADDRESS 4600 Liberty Hghts. Avenue	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORDS OF DEATH

RECORD

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FOR STATE
HEALTH DEPT.

00280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00282

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 5 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2005 Frames Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laurie Middle Elmer Last Griffin		4. DATE OF DEATH Month January Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/90
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jim Griffin		14. MOTHER'S MAIDEN NAME Elizabeth Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 237-28-8158	
17. INFORMANT (Son) James Griffin		Address 21224 1420 Bonsol St. Balto. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) AS-C-V-DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis		M.D. M.D.	
22. DATE SIGNED 1/13/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk, Md.	
Address (Street, city, town, or county) 6800 Morningside Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/15/67	23c. NAME OF CEMETERY OR CREMATORY Rosebud Christian Cemetery	23d. LOCATION (City or Town) (County) (State) Walnut Cove, N. C.
24. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	
25a. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Journal of Management Inquiry 22(1) 3-14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00281

CERTIFICATE OF DEATH

00283

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Arbutus 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		d. STREET ADDRESS 1310 Poplar Avenue	
3. NAME OF DECEASED (Type or print) MARIE C. GROSS		4. DATE OF DEATH Month January Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-1879
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Alheit		14. MOTHER'S MAIDEN NAME Agnes Albright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Edna Button, 1310 Poplar Ave. 21227		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) DUE TO C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 8 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 24, 1966 to Jan 9, 1967 that (I) (we) last saw the deceased alive on Dec 24, 1966 and that death occurred at 3:00 AM from causes and on the date stated above.			
22a. SIGNATURE Earl I. Pass M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass		22d. ADDRESS 4001 Wilkens Ave, Balto., Md. 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF XXX 1-7-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JAN 9 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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CRIMINAL RECORD

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FOR STATE
HEALTH DEPT.

00282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00284

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Rural c. LENGTH OF STAY IN lb Baltimore Rural d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 34 Yorkway		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Rural (DUNDALK) d. STREET ADDRESS 34 Yorkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle M/ Last HABICHT		4. DATE OF DEATH Month January Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1909 9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Urbancik		14. MOTHER'S MAIDEN NAME Mary Shrachovec	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-3520	17. INFORMANT Carl W. Habicht 34 Yorkway 21222 Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compression of Cervical Spinal Cord DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of Cervical Vertebra, C4. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down steps	
20c. TIME OF INJURY Month, Day, Year Hour XXXX 1/14 1967 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 1/15/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/67	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md. ADDRESS		25a. RECD. BY REGISTRAR JAN 15 1967 DATE 25b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00283				CERTIFICATE OF DEATH				00285			
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <u>13.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>309 LOCUST DRIVE</u>						d. STREET ADDRESS <u>309 LOCUST DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>G.</u> Last <u>HARDY</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>1</u> Year <u>1967</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 26, 1920</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD. PENITENTARY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>JAMES D. HARDY</u>						14. MOTHER'S MAIDEN NAME <u>EMMA BALLADARICH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>212-01-4271</u>		17. INFORMANT <u>Mrs. James J. Hardy - 309 Locust Drive</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> <u>Carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> DUE TO (c) <u>163X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 5</u> , 19 <u>54</u> , to <u>Jan 1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 1</u> , 19 <u>67</u> , and that death occurred at <u>49</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Kennard Yaffe</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENNARD YAFFE</u>						22d. ADDRESS <u>5501 Forest Park Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto.</u> <u>Ind.</u>					
24. FUNERAL DIRECTOR <u>Forley-Corway & Son, Catonsville, Ind.</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 6</u> 19 <u>67</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00286

1. PLACE OF DEATH a. COUNTY Towson Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb Baltimore #14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1905 Swansea Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Harrell		4. DATE OF DEATH Month 1 Day 14 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-1913
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 Year Months Days Hours Min. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gary Sullivan		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-22-9961	
17. INFORMANT Mr. Wesley B. Harrell		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Insufficiency DUE TO (c) St. Mork		INTERVAL BETWEEN ONSET AND DEATH 5 St. Mork	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 1/14/67.	
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REBURY (Specify) Burial		23b. DATE THEREOF 1/18/67.	
23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Cemetery		23d. LOCATION (City or Town) (County) (State) Eldersburg, Carroll, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

00285

CERTIFICATE OF DEATH

00287

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 59 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 530 SOUTH HANOVER ST.	
3. NAME OF DECEASED (Type or print) First ROBERT Middle ABRAHAM Last HART		4. DATE OF DEATH Month JANUARY Day 2 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH APRIL 19, 1880
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months Days Hours Min. 2 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) FRANKLIN, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JUNIUS HART	
14. MOTHER'S MAIDEN NAME MINNIE WELLS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES S.A.W.	
16. SOCIAL SECURITY NO. 217 22 91 26		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) CARCINOMA HEAD OF PANCREAS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (A) (this hospital) attended the deceased from NOV. 4 , 19 66 , to JAN. 2 , 19 67 , that (A) (we) last saw the deceased alive on JAN. 2 , 19 67 , and that death occurred at 250P M. from causes and on the date stated above.	
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 1/3/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY EASTLAWN		23d. LOCATION (City or Town) (County) (State) WILLIAMSTOWN, MASS.	
24. FUNERAL DIRECTOR <i>Charles A. Rice</i>		25a. REC'D BY REGISTRAR DATE JAN 6 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles A. Rice</i>		26. W. BARRE ST. BALTIMORE, MD.	

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CHARTER OF DEATH

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may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00286

00288

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Amargost Nurs Home</u> <u>815 Register Ave.</u>				d. STREET ADDRESS <u>3333 N. Charles St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry S. Hartman</u>				4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 24 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INVESTMENTS</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Esther</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Nurs. Home Chart</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u>		(County) <u>—</u>		(State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 31 1964</u> to <u>Jan 21 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 19 1967</u> and that death occurred at <u>8 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel V. Lindenstruth</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL V. LINDENSTRUTH, MD</u>				22d. ADDRESS <u>7501 York Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/24/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Finkbeiner</u>				ADDRESS <u>Baltimore</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>JAN 25 1967</u>	

88500

CONTROL OF DEATH

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00288

CERTIFICATE OF DEATH

00290

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b Relay	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 406 Gun Road		d. STREET ADDRESS 406 Gun Road	
3. NAME OF DECEASED (Type or print) WILLIAM D. GILL HEDEMAN		4. DATE OF DEATH Month January Day 31 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-1882
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 13 Days 1 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hedeman		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-7795	
17. INFORMANT Mrs. Nettie M. Hedeman, 406 Gun Road		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Cardio-Vascular disease DUE TO (c) Chlorimithis of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 24, 1967 to Jan 31, 1967 that (I) (we) saw the deceased alive on Jan 30, 1967 , and that death occurred at 8:30 A.M. from causes and on the date stated above			
22a. SIGNATURE Dr. Bruce Brumbaugh		22b. DATE SIGNED 2/1/67	
22c. PHYSICIAN'S NAME (Type) Dr. Bruce Brumbaugh		22d. ADDRESS 5609 Main Street, Elkridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-2-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) 3801 Frederick Ave. Balto. Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR 21229	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10yr7mth23dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Saimi (Saima) Heikkila		4. DATE OF DEATH January 17 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? Finland	
13. FATHER'S NAME Samuel Setala		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO (b) Arteriosclerotic cardiovascular heart Dis 5 yrs. DUE TO (c) Arteriosclerosis, Generalized 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Combined mitral stenosis and insufficiency & Pul. Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that at (this hospital) attended the deceased from May 24 19 56 , to Jan. 17, 19 67 , that it (we) last saw the deceased alive on Jan. 17 19 67 , and that death occurred at 10:10 M, from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 1-17-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 1/20/67	
23c. NAME OF CEMETERY OR CREMATORY Yolub Funeral Home, Cleveland, Ohio.		23d. LOCATION (City or Town) (County) (State) (Cleveland, Ohio.)	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00290

CERTIFICATE OF DEATH

00292

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Josephs Hospital</u>		d. STREET ADDRESS <u>3517 Denison Rd. 21215</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>A.</u> Last <u>HEIL</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1896</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Tea Blender</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Philip Heil</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW I</u>		18. SOCIAL SECURITY NO. <u>215-05-6816</u>	
19. INFORMANT <u>Margaret Weller Heil - 3517 Denison Rd.</u>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X Lobular pneumonia involving right and left</u> <u>upper lobes.</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease; Asthma.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 7, 1967</u> , to <u>January 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 8, 1967</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence F. M. sanik, M.D.</u>		22b. DATE SIGNED <u>1/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence F. M. sanik, M.D.</u>		22d. ADDRESS <u>7620 York Road, Towson, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-10-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Elsworth Hines</u>		25a. REC'D BY REGISTRAR <u>JAN 9 1967</u>	
ADDRESS <u>4600 Liberty Hghts. Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-62

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN b 17 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 31 Pleasant Hill Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 31 Pleasant Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eli Edward Hewitt		4. DATE OF DEATH Month Day Year January 21, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1921
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Poultry Farm	
11. BIRTHPLACE (County & State, or foreign country) Glyndon, Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli Russler Hewitt		14. MOTHER'S MAIDEN NAME Sarah M. Cox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-14-0614	
17. INFORMANT Mrs. Georgia W. Hewitt		Address 31 Pleasant Hill Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Adeno-carcinoma of small intestine (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. est. 1½ yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (XXXXXX) attended the deceased from 6-24-38 , 19....., to 1-21-67 , 19....., that (I) (yes) last saw the deceased alive on 1-20-67 , 19....., and that death occurred at 8 a.m. from the causes and on the date stated above.			
22a. SIGNATURE D. D. Caples M.D.		22b. DATE SIGNED 1-23-67	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/24/67	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION (City, town or county) (State) Finksburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE A. J. Schaub ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR DATE JAN 24 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00294

00292

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>13.1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRIDGEWAY Nursing Home.</u>		d. STREET ADDRESS <u>1000 W. EDMONDSON AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>N.</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1886</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>CHURCHTON, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN WINDSOR</u>		14. MOTHER'S MAIDEN NAME <u>MARY HOWES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>BERNARD FELD</u>		Address <u>1002 ASTER BLVD. ROCKVILLE, MD. 20850</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>9 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-10</u> , 19 <u>65</u> , to <u>1-15</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>1-13-</u> , 19 <u>67</u> , and that death occurred at <u>6:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave</u> <u>1-15-67</u>			
ACTUAL SIGNATURE <u>Wilmer K. Ballager</u>		M.D. <u>Baltimore, 21228 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Ballager</u>		M.D. <u>Baltimore, 21228 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-18-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 18 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

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1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
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49. Signature of jury		50. Signature of jury		51. Signature of jury	
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55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

FOR STATE
HEALTH DEPT.

00293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00295

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OELLA MD</u>		c. LENGTH OF STAY IN 1b <u>79 YR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OELLA MD 03.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>763 OELLA AVE</u>				d. STREET ADDRESS <u>763 OELLA AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST (NMI) HOBSON</u>				4. DATE OF DEATH Month Day Year <u>JAN 2 19 67</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 18 1887</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SPINNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEXTILE MFG</u>		11. BIRTHPLACE (State or foreign country) <u>OELLA MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HOBSON</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA REESE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213096008</u>		17. INFORMANT <u>MRS JOHN HOBSON</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.0 IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John N. Snyder</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN N. SNYDER</u>		Address (Street, city, town, or county) <u>6348 FREDERICK</u>		22. DATE SIGNED <u>1/2/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GOOD SHEPHERD</u>		23d. LOCATION (City or Town) (County) (State) <u>ELLKOTT CITY MD</u>	
24. BURIAL DIRECTOR <u>F.C. RIGGIN BROTHERS, ELLKOTT CITY MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 4 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00294						00296					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			BALTIMORE			a. STATE			MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Towson			b. COUNTY					
c. LENGTH OF STAY IN 1b			10 DAYS			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
GREATER BALTIMORE MEDICAL CENTER						814 E. 33 rd STREET			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
JOHN E HOGBERG						JAN 30 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		CAUC				1-16-89		78 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Carpenter				Gen'l Contractor		SWEDEN				U. S. A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JOHN P. HOGBERG						?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
No				None		110-12-1517 Mr. John Hagenbucher				1505 Lakeside Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH METASTASES										2 YRS.	
177X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 1-21, 1967, to 1-30, 1967, that (I) (we) last saw the deceased alive on 1-30 1967, and that death occurred at 3:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Evelyn L. Ramos M.D.										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EVELYN L. RAMOS, M.D.										22d. ADDRESS	
										GREATER BALTIMORE MEDICAL CENTER	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			2/3/1967			Immanuel Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. J. Johnson & Sons						FEB 2 1967		J. Charles Young			

00388

00388

ORGANISM OF INTEREST WITH MEDICAL

00295

CERTIFICATE OF DEATH

00297

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 74 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1701 NORTH FULTON AVENUE	
3. NAME OF DECEASED (Type or print) First PHILIP Middle W. Last HOLLAND		4. DATE OF DEATH Month JANUARY Day 7 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 6, 1896
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY BAKERY	
11. BIRTHPLACE (County & State, or foreign country) CATONSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD HOLLAND		14. MOTHER'S MAIDEN NAME CARRIE WOODLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 214 26 94 88	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT SUBPHRENIC ABSCESS DUE TO (b) GASTRIC ULCER WITH PERFORATION DUE TO (c) CEREBRAL THROMBOSIS, OLD			INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CEREBRAL THROMBOSIS, OLD			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 17 (this hospital) attended the deceased from OCT. 25 , 19 66 , to JAN 7 , 19 67 , that 17 (we) last saw the deceased alive on JAN 7 , 19 67 , and that death occurred at 11:45 PM , from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 1/9/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b. DATE THEREOF 1/12/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Marshall P. Hayes		25a. REC'D BY REGISTRAR 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS HAYES FUNERAL HOME	
25d. ADDRESS N. GILMOR ST. BALTIMORE, MD.		25e. ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00298									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural - near Howard</u> c. LENGTH OF STAY IN 1b <u>7 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4402 Vale Drive 36</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural</u> <u>03.1</u> d. STREET ADDRESS <u>4402 Vale Drive 36</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>RUSSELL CLYDE HOOPER</u> First Middle Last 4. DATE OF DEATH <u>Jan 18 1967</u> Month Day Year					5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 23 1901</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNOER 1 YEAR Months Days IF UNOER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> 11. BIRTHPLACE (State or foreign country) <u>Harroburg Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>George Austin Hooper</u> 14. MOTHER'S MAIDEN NAME <u>Ceceline E Wise</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>214-16-5543</u> 17. INFORMANT <u>Helen A Hooper</u> Address <u>4422 Vale Drive 21236</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> 976X DUE TO (b) <u>Depression</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Depression</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depression</u>				
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun shot wound of head</u>					20c. TIME OF INJURY Month, Day, Year <u>1-3 p.m. 1-18 1966</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John C. Hyde</u> EXAMINER'S NAME (Type) <u>JOHN C. Hyde</u>					22. DATE SIGNED <u>1-18-67</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan 24 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mezdownridge Mem Park</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Burgen General Home</u> ADDRESS <u>3639 Falk Rd Baltimore</u>					25a. REC'D BY REGISTRAR <u>John Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u> DATE <u>JAN 24 1967</u>				

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[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page. Some words like "JAN 19" and "1918" are faintly visible.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00299											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
GREATER BALTIMORE MENIAL CENTER						28 Warren Rd.					
3. NAME OF DECEASED (Type or print) BABY GIRL HORN						4. DATE OF DEATH JAN 17 1967					
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-67		9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR 3 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Balto. - Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward H Horn						14. MOTHER'S MAIDEN NAME Joy Ruth Oakes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Admission Sheet.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE MEMBRANE DISEASE 773.5 DUE TO (b) PREMATURE INFANT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 30 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from 1-14 , 19 67 , to 1-17 , 19 67 , that the (we) last saw the deceased alive on 1-17 , 19 67 , and that death occurred at 10 A.M. from the causes and on the date stated above.											
22a. SIGNATURE James T. Stinnett, III						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-17-67			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL (CREMATION) REMOVAL (Specify)				23b. DATE THEREOF JAN 18, 1966		23c. NAME OF CEMETERY OR CREMATORY GREATER BALTO. MED. CTR.		23d. LOCATION (City, town or county) (State) 6701 N. CHARLES BALTO. MD.			
24. FUNERAL DIRECTOR Barbara J. Peterson, M.D.				ADDRESS 6701 N. CHARLES BALTO. MD.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
						DATE JAN 26 1967					

7-233645

1990

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
00287						00289																	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> c. LENGTH OF STAY IN 1b <u>18 mo's</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Nursing Home - Rolling Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD (Birdsboro)</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4201 WESTVIEW RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>March</u> <u>Haw</u>			4. DATE OF DEATH <u>1-14-67</u>			5. SEX <u>7</u>			6. COLOR OR RACE <u>W</u>														
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Oct 29-1884</u>			9. AGE (In years last birthday) <u>82</u> yrs.			10. IF UNDER 1 YEAR Months Days														
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			11b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Birdsboro, Penna</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>														
13. FATHER'S NAME <u>Isaac March</u>						14. MOTHER'S MAIDEN NAME <u>Sara Livingston Birdsboro, Pa.</u>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Broncho - Pneumonia</u> DUE TO (b) <u>Advanced Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1967</u> to <u>Jan 14, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 13, 1967</u> , and that death occurred at <u>1300</u> M, from the causes and on the date stated above.																							
22a. SIGNATURE <u>Wetherbee Fort</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>1/14/67</u>						22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>						22d. ADDRESS <u>6 Dutton Ave. Catonsville 28</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1/17/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHELS</u>				23d. LOCATION (City, town or county) (State) <u>BIRDSBORO, PA</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOAN F. DENNY, INC.</u>						ADDRESS <u>715 LIGHT ST. BALTO, MD</u>						25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>											
												25b. REGISTRAR'S SIGNATURE											

72500

20770

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00298									
1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville, Md.</u> 03.1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater BALTO Med Center</u>					d. STREET ADDRESS <u>324 Warren Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Roy</u> Last <u>Howard</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>27</u> Year <u>1967</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/29/1892</u>		9. AGE (in years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Self emp. Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JosHA Howard</u>					14. MOTHER'S MAIDEN NAME <u>Helen MAGASON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>			16. SOCIAL SECURITY NO. <u>217-03-1690</u>		17. INFORMANT <u>Pt's history</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>153.8</u> DUE TO (b) <u>Metastatic carcinoma</u> DUE TO (c) <u>Adenocarcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13</u> , 19 <u>66</u> , to <u>Jan 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 27</u> , 19 <u>67</u> , and that death occurred at <u>1:35</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert W. Smith</u>								22b. DATE SIGNED <u>1-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Smith</u>					22d. ADDRESS <u>G.B.M.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u>		
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

00234

00100

Abnormalities of action
motoric character
Cardiographic failure

Robert W. Smith

X 1-21-07

Dec. 13 1894 Jan 21 07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00299

CERTIFICATE OF DEATH

00301

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>14 yr + 7 mo</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AGED WOMENS + AGED MENS HOME</u>		d. STREET ADDRESS <u>3016 BELMONT AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA M. HOWARD</u>		4. DATE OF DEATH Month Day Year <u>JAN 20 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-1872</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Disney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Gloria Sherman</u>		Address <u>615 Chestnut are Towson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 ASCVD</u> DUE TO (b) <u>Bacterial pneumonia</u> DUE TO (c) <u>3 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Breast?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 16</u> , 19 <u>52</u> , to <u>Jan. 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 20</u> , 19 <u>67</u> , and that death occurred at <u>9:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>January 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEWLAND E. DAY</u>		22d. ADDRESS <u>4-6-33rd St Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-23-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jessops Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville md.</u>	
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson Inc</u>		25a. REC'D BY REGISTRAR <u>1050 York Rd Towson, Md. 21204</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		DATE <u>JAN 25 1967</u>	

10000

RECEIVED BY DEPT

00529

1970

Handwritten notes and stamps, including a large circular stamp with the number 100.

Handwritten notes and stamps, including a large circular stamp with the number 100.

Vertical text on the right margin, possibly a date or reference number.

00300

CERTIFICATE OF DEATH

00302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN lb 106 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21229			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1038 COOKS LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First PERCY Middle E. Last HOWARD				4. DATE OF DEATH Month JANUARY Day 5 Year 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 7, 1890		
9. AGE (In years birthday) yrs. 76		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK CLERK			10b. KIND OF BUSINESS OR INDUSTRY KOPPERS COMPANY		11. BIRTHPLACE (County & State, or foreign country) CALVERT COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. HOWARD				14. MOTHER'S MAIDEN NAME ELLA E. SHERBERT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 219 10 15 47		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS XOXOX (b) CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) GENERALIZED ARTERIOSCLEROSIS							INTERVAL BETWEEN CAUSE AND DEATH MONTHS MONTHS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from 9/21/66 , 19__ to 1/5/67 , 19__, that (I) (we) last saw the deceased alive on 1/5/67 , 19__, and that death occurred at 8:40AM on the date stated above.								
22a. SIGNATURE <i>George Dudas</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/5/67		
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jan. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME				25a. REC'D BY REGISTRAR JAN 6 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00301		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				00304			
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Point Area c. LENGTH OF STAY IN 1b MD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7901 Baltimore St.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 7901 E. Baltimore St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Clara M. Hubbard First Middle Last					4. DATE OF DEATH Jan 21, 1967 Month Day Year				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1907		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Rohleder					14. MOTHER'S MAIDEN NAME Lillian Bechers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 100-100000-0000		17. INFORMANT Melvin P. Hubbard Address 7901 Baltimore St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-Disease 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hypertension								INTERVAL BETWEEN ONSET AND DEATH 422.1	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE MB Davis					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. Melvin B. Davis					22. DATE SIGNED 1/23/67				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/24/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Dippel Bro's. Inc. 1800 E. Lombard St.					25a. REC'D BY REGISTRAR JAN 25 1967 DATE				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN lb <u>8 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Agnes Womack and Sons Home</u>		d. STREET ADDRESS <u>Savage</u> <u>13.2</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs Mary Ann Hunt</u> First Middle Last		4. DATE OF DEATH <u>January 26</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1896</u> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Savage, Md.</u>	
13. FATHER'S NAME <u>Joseph Bounds</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-10-1143</u>	
17. INFORMANT <u>Daisy E. Hammett</u>		Address <u>615 Chestnut Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCD, Pulmonary Edema</u> DUE TO (b) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>36 hrs</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 18</u> , 19 <u>49</u> , to <u>Jan. 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 26</u> , 19 <u>67</u> , and that death occurred at <u>10:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Neiland Edward Day</u> M.D.		22b. DATE SIGNED <u>1-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>N.E. DAY</u> M.D.		22d. ADDRESS <u>4-E-33 St Baltimore 21218 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>JAN. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRACE Methodist Church</u>	23d. LOCATION (City or Town) (County) (State) <u>SAVAGE MD.</u>
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Inc.</u> <u>1217 St. Paul St - Baltimore 2. MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 30 1967</u>			

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CHURCH OF DEATH

A26VD. February 1960

Michael Edward Bay

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Maiden Choice Lane		d. STREET ADDRESS 107 Maiden Choice Lane	
3. NAME OF DECEASED (Type or print) CHARLES D. IRWIN		4. DATE OF DEATH Month January Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1898
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dock Hand		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Irwin		14. MOTHER'S MAIDEN NAME Elizabeth Lewe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-4561A	
17. INFORMANT Mrs. Elizabeth O. Irwin, 107 Maiden Choice Lane		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO (b) Emphysema, chronic DUE TO (c) 527.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parenchymal lung fibrosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 14 , 19 67 , to Jan 17 , 19 67 , that (I) (we) last saw the deceased alive on Jan 17 , 19 67 , and that death occurred at 2:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert B. Taylor MD		22b. DATE SIGNED 1-18-67	
22c. PHYSICIAN'S NAME (Type) Dr. Robert B. Taylor		22d. ADDRESS 111 Columbia Road, Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-21-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		25a. RECD BY REGISTRAR 21229	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND **DEPARTMENT OF HEALTH**
00304 001 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 00307

1. PLACE OF DEATH a. COUNTY Baltimore Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Reisterstown c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1003 Dunholm Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY Baltimore Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Reisterstown d. STREET ADDRESS 1003 Dunholm Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William V. Middle Ischer Last Ischer		4. DATE OF DEATH Month January Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 95
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 1	IF UNDER 24 HRS. Hours 1 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Phillip Ischer	
14. MOTHER'S MAIDEN NAME Elizabeth Gerwig		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WWI	
16. SOCIAL SECURITY NO. 215-32-9434		17. INFORMANT Address Margret C. Ischer 1003 Dunholm Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - acute DUE TO 4/20/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis - generalized DUE TO years (c) Conjunctive Heart Failure - Chronic 6 months		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 15, 1966 to January 1, 1967 , that (I) (we) last saw the deceased alive on December 15, 1966 , and that death occurred at 3:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Clarence E. McWilliams M.D.		22b. DATE SIGNED 1-1-67	
22c. PHYSICIAN'S NAME (Type) Clarence E. McWilliams M.D.		22d. ADDRESS 11904 Reisterstown Rd Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-5-67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville Md.
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Inc.		25a. REC'D BY REGISTRAR JAN 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

MARYLAND STATE DEPT
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00305						00308					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY IN 1b 73 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 814 E Street						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point 21219 d. STREET ADDRESS 814 E Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOLA			First Middle Last MCCLARY ISENNOCK			4. DATE OF DEATH 5 January 1967			Month Day Year		
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1876		9. AGE (In years last birthday) 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nelson McCleary						14. MOTHER'S MAIDEN NAME Martha Gill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216/54/6937		17. INFORMANT Bertha I. Adams (as in 2 above)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Myocardial Infarction DUE TO (b) Unlabeled Unconscious Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July , 1950, to Jan 5 , 1967, that (I) (we) last saw the deceased alive on Jan 5 , 1967, and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE James T. Means						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1-6-67		
22c. PHYSICIAN'S NAME (Type) James T. Means						22d. ADDRESS 520 D St. Balto. Md 21219					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/9/1967		23c. NAME OF CEMETERY OR CREMATORY Clynnalira			23d. LOCATION (City, town or county) (State) Monkton, Balto. Co., Md			
24. FUNERAL DIRECTOR Walter Brooks Bradley						ADDRESS Dundalk, Md.			25a. REC'D BY REGISTRAR J. Charles Judge		
						25b. REGISTRAR'S SIGNATURE			DATE JAN 9 1967		

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Bellevue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00306

Items 1c, 14 Film G385 1/21/67 mh

CERTIFICATE OF DEATH

00309

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN 1b 3 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Towson Conv. Home		d. STREET ADDRESS 220 Division Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Paul First James Middle James Last		4. DATE OF DEATH Month Jan. Day 17 Year 1967	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1880
9. AGE (In years 86 birthday) yrs.		10. IF UNDER 1 YEAR Months 8 Days 6 Hours 19 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of preceding year) Super. Genesco		12. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. FATHER'S NAME Charles James		14. MOTHER'S MAIDEN NAME Hannah Thiele/ Anna Thiele	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214 01 3415	
17. INFORMANT Mrs. A.H. Gilpin,		18. ADDRESS 220 Division Ave, Lutherville Md. 21093	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December, 1963 to Jan. 17, 1967 , that (I) (we) last saw the deceased alive on Jan. 16, 1967 , and that death occurred at 11 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Lloyd E. Saylor		22b. DATE SIGNED 1/19/67	
22c. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		22d. ADDRESS 3902 Greenmount Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF 1-21-67	23c. NAME OF CEMETERY OR CREMATORY Lorraine	23d. LOCATION (City or Town) (County) (State) Woodlawn, Baltimore, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE JAN 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

2080254

00307

CERTIFICATE OF DEATH

Reg. Dist. No. 00310

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Bato.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 13.1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 726 Martin Drive				d. STREET ADDRESS 726 Martin Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edna Middle K. Last Jenkins			4. DATE OF DEATH Month Jan. Day 24 Year 19 67				
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-91		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Late - --- Kroeger				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Mr. Howard Jenkins 14 Somerset Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Occlusion 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) After severe trauma Cerebral Vascular Disease DUE TO (c) 6 yrs.							INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 24 , 19 67 , to Jan 24 , 19 67 , that I last saw the deceased alive on Jan 24 , 19 67 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6014 Edmondson Ave. DATE SIGNED Jan 25, 1967							
ACTUAL SIGNATURE Nelson Mc Kay			M.D. 6014 Edmondson Ave.				
PHYSICIAN'S NAME (Type) Nelson Mc Kay, M. D.			6014 Edmondson Ave.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-67		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE JAN 27 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

00310

CERTIFICATE OF DEATH

00367301

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DIVISION OF VITAL RECORDS
BOSTON, MASSACHUSETTS

DATE OF DEATH: _____
PLACE OF DEATH: _____
AGE: _____
SEX: _____
RACE: _____
MARRIAGE: _____
OCCUPATION: _____
EDUCATION: _____
RELIGION: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE: _____
DATE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00308						00311					
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b For years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY city c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) city d. STREET ADDRESS 1554 Lochwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edward Baker Johnson			4. DATE OF DEATH Month Jan. Day 28 Year 1967			5. SEX Male			6. CILDR DR RACE white		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7-22-89			9. AGE (In years last birthday) 77 yrs.			10. IF UNDER 1 YEAR Months 77		
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Johnson			14. MOTHER'S MAIDEN NAME Ella Tensfield		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 212-28-5866			17. INFORMANT Records, Mt. Wilson State Hospital			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from 11-25, 1966 , to 1-28, 1967 , that (I) (we) last saw the deceased alive on 1-28, 1967 , and that death occurred at 11:40 AM , from the causes and on the date stated above.		
22a. SIGNATURE Wm. Newcomer			22b. DATE SIGNED 1-28-67			22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			22d. ADDRESS Mount Wilson, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb 1, 1967			23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			23d. LOCATION (City, town or county) Taylor Ave. Md		
24. FUNERAL DIRECTOR Austin E. Donovan			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			25c. DATE JAN 31 1967		

00311

00308

Belmont County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

W. Newcomer, M.D., Superintendent, Mount Wilson, Maryland

Funeral, Feb. 1, 1907, Newland Memorial Park, Taylor Ave., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b White Hall, 21161 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall, 21161 d. STREET ADDRESS Bradenbaugh Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Todd JOHNSON				4. DATE OF DEATH Month Day Year January 31, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1890	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Joseph Howard				14. MOTHER'S MAIDEN NAME Elizabeth Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217182508		17. INFORMANT Eva B. Johnson		Address White Hall 21161	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/16/ , 19 67 , to 1/31/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/31/ 19 67 , and that death occurred at 8:45 M., from causes and on the date stated above.							
22a. SIGNATURE Melvin A. Ventum				M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George W. Tittle				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-1967		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City or Town) (County) (State) Shawee Baltimore Md	
24. FUNERAL DIRECTOR George W. Tittle				25a. REC'D BY REGISTRAR DATE FEB 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

01810

1914

1914

Went in

Went in
Went in
Went in

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00309
00312
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 14 mo 23 d d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2806 2nd Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Era Virginia Kates		4. DATE OF DEATH Month Day Year 1 14 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11.29.88
9. AGE (in years last birthday) 78 yrs.		10. IF FUNERAL 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Lawrence Mallonee		14. MOTHER'S MAIDEN NAME Katherine Mc Gee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-54-0960	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 102.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hiatal hernia, Exfoliative Psoriasis. INTERVAL BETWEEN ONSET AND DEATH 15 mo.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10.22.1965 , to 1.14.1967 , that (I) (we) last saw the deceased alive on 1.14.1967 , and that death occurred at 12:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 1.14.67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt.		22d. ADDRESS Mount Wilson, Maryland	
23a. DATE CREMATION, DATE (Specify)		23b. DATE THEREOF 1-17-67	
23c. NAME OF CITY OR CREMATORY GREENMOUNT		23d. LOCATION (City, town or county) (State) BALTO MD	
24. FUNERAL DIRECTOR Chas. F. Evanson		25a. REC'D BY REGISTRAR 8802 Hartford Rd	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JAN 17 1967	

00315

00315

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mount Wilson State Hospital

Mount Wilson, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00310

CERTIFICATE OF DEATH

00313

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 8621 WOODSPRING ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DR. ALBERT HERBERT KATZ				4. DATE OF DEATH JANUARY 24 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 23, 1914		9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY MEDICINE		11. BIRTHPLACE (County & State, or foreign country) DUBOIS, PENNA		12. COUNTRY OF WHAT CITIZEN? U.S.A.	
13. FATHER'S NAME MARCUS KATZ				14. MOTHER'S MAIDEN NAME JENNY SHULMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16. SOCIAL SECURITY NO. 212 32 84 81		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: 430.1 PNEUMONIA, BILATERAL IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ENDOCARDITIS, ACUTE (c)						INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MULTIPLE SCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN. 18 , 19 67 , to JAN. 24 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JAN. 24 , 19 67 , and that death occurred at 925 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/25/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/26/67		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEMETERY		23d. LOCATION (City or Town) (County) (State) WINDSOR MILL RD. BALTO. MD.	
24. FUNERAL DIRECTOR		ADDRESS SOL LEVENSON & BROTHERS		25a. REC'D BY REGISTRAR JAN 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00314

1. PLACE OF DEATH a. COUNTY <u>BAL TO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BAL TO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>03.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 FAIRWAY RD.</u>				d. STREET ADDRESS <u>1 FAIRWAY</u>			
3. NAME OF DECEASED (Type or print) <u>PAUL K. KEPNER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 18-1900</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GLEN-MARTIN</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Levi KEPNER</u>				14. MOTHER'S MAIDEN NAME <u>HOFFINE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>173-03-0857A</u>		17. INFORMANT <u>WIFE</u> Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>A-S-C-U-Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.				22. DATE SIGNED <u>1/28/67</u>			
EXAMINER'S NAME (Type) <u>M. B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>1/31/67</u>		<u>Oak-Lawn Cem</u>		<u>Balto</u> <u>MD.</u>	
24. FUNERAL DIRECTOR <u>J. G. Connelly Sons - 300 MACE (21)</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 31 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00312

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00315

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK	
c. LENGTH OF STAY IN lb 18 with		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSP.		d. STREET ADDRESS 5016 LAKELAND RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AURELIA Middle KINARD Last KINARD		4. DATE OF DEATH Month JAN. Day 9 Year 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/96
9. AGE (in years last day) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDMUND ABRAMS		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 251-07-9995	
17. INFORMANT AMART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC VASCULAR DISEASE DUE TO 4500 (b) URINARY TRACT INFECTION DUE TO DECUBITUS ULCER INFECTED (c) TRACTURE OF LEFT FEMUR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 MONTH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SINOBRONCHOPULMONARY DISEASE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL from a chair 10/5/65	
20c. TIME OF INJURY Month, Day, Year 10/5/65 Hour 6.00 a.m. 10 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove Hosp.		20f. (City or town) (County) (State) Catonsville Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE P. K. K. K.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. KASARI'S, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1/9/67	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-15-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Helborn Baptist em.		23d. LOCATION (City or Town) (County) (State) Clinton S.C.	
24. FUNERAL DIRECTOR Rev. A. Nelson		25a. REC'D BY REGISTRAR 1348 n. Calhoun st	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JAN 13 1967	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
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00313

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00316

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hamilton Place Farm				d. STREET ADDRESS Hamilton Place Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DORA First YATES Middle King Last		4. DATE OF DEATH Jan 6 19 67		5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/80		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 6 Days 6 IF UNDER 24 HRS. Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson YATES				14. MOTHER'S MAIDEN NAME Mertice Browning			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-36-6773		17. INFORMANT H. M. Grayson (niece) some Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiac Vascular Disease 422.1 DUE TO (b) - Aging & terminal dehydration's Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cachexia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-6-67 DATE SIGNED							
ACTUAL SIGNATURE John C. Hyle		M.D. John C. Hyle					
EXAMINER'S NAME (Type) JOHN C. Hyle		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 1/6/67		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR The S.H. Hines Company Washington, D.C.		24a. REC'D BY REGISTRAR JAN 9 1967		24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00314					00317						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY			Baltimore		a. STATE			Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rogers Forge Community		b. COUNTY			Baltimore			
c. LENGTH OF STAY IN 1b			202 Overbrook Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rogers Forge Community 21212 13.1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH			Month Day Year			
First Middle Last					January 14, 1967						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.			
Female		White				December 10, 1885		81 yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife			Own Home			Maryland			USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Singleton Howes					Maria Howes						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFIRMANT Address	
No					None					Family records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									years		
420.0 Arteriosclerotic Heart Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									years		
DUE TO (b) Generalized Arteriosclerosis											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from Jan 1964, to Jan 1967, that (I) (we) last saw the deceased alive on Jan 1967, and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
Layriston H. KEDOWN M.D.					16 Jan 67						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
Layriston H. KEDOWN M.D.					431 East Lake Ave Baltimore Md 21212						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			Jan. 17, 1967		Meadowridge Memorial Cem.			Elkridge, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE						
John Burns' Sons, Towson, Maryland					DATE JAN 19 1967						

00317

00318

James H. Hester
James H. Hester

at 11:00

from

at

11:00

James H. Hester
James H. Hester

at 11:00

at 11:00

at 11:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00315

00318

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 2 mo 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS 17.2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CURTIS First Davis Middle KIRK Last		4. DATE OF DEATH Month 1 Day 14 Year 1967					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-04	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad engineer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Cecil Kirk				
14. MOTHER'S MAIDEN NAME ALICE DAVIS			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				
16. SOCIAL SECURITY NO. 160-16-2669			17. INFORMANT Records, Mt. Wilson State Hospital Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 527.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Pulmonary Emphysema DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —				INTERVAL BETWEEN ONSET AND DEATH 12 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 11-3-1966 to 1-14-1967 , that (I) (we) last saw the deceased alive on 1-14-1967 , and that death occurred at 10 AM , from the causes and on the date stated above.					
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 1-14-67		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22d. ADDRESS Mount Wilson, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					
23b. DATE THEREOF 1/17/67		23c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM		23d. LOCATION (City, town or county) (State) COLORA CECIL, MD.			
24. FUNERAL DIRECTOR RALPH M. REED		25a. REC'D BY REGISTRAR RISING SUN, MD		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

00312

00312

Baltimore County

Mount Wilson

Mount Wilson State Hospital

CHURCH

Dave

KIRK

ALICE DAVIS

Records, Mt. Wilson State Hospital

Mr. Raymond A. D. Superintendent, Mount Wilson, Maryland

11/17/57 WEST MOUNTAIN

RAFAEL

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00316

CERTIFICATE OF DEATH

00319

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>548 Sudbrook Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>548 Sudbrook Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Klasman</u> Middle <u>Lane</u> Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRA</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			4. DATE OF DEATH <u>January 9</u> 19 <u>67</u> Month <u>January</u> Day <u>9</u> Year <u>1967</u> 8. DATE OF BIRTH <u>July 21, 1910</u> 9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.				
13. FATHER'S NAME <u>Max Klasman</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>213-36-2040</u> 17. INFORMANT <u>Edna Klasman</u> Address <u>548 Sudbrook Lane</u>		14. MOTHER'S MAIDEN NAME <u>Bessie</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Ac Myocardial Infarction</u> (c) <u>(massive)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov 30</u> , 19 <u>63</u> to <u>Jan 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 9</u> , 19 <u>67</u> , and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard Applefield</u> 22c. PHYSICIAN'S NAME (Type) <u>Willard Applefield</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>5501 Park Heights Dr</u>		22b. DATE SIGNED <u>1/5/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan 10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Reisterstown, Md</u> 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR <u>Sal Reunion & Son - 6000 Reisterstown</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JAN 13 1967</u>			

00318

00318

2501 Park Street N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00317						CERTIFICATE OF DEATH			00320			
1. PLACE OF DEATH a. COUNTY <u>Maryland Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>30.4</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>90 Milford Manor Nursing Home</u>						d. STREET ADDRESS <u>3001 Chelsea Terrace</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Kleeman</u> Last <u>Kleeman</u>						4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>			12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>			
13. FATHER'S NAME <u>Abraham Bamberger</u>						14. MOTHER'S MAIDEN NAME <u>Theresia?</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mr Segi Kleeman</u> Address <u>6701 Maureen Rd</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , 19 <u>67</u> , to <u>Jan. 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6, 1967</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.												
22a. SIGNATURE <u>Herbert Goldstone</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>Jan. 7, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>HERBERT GOLDSTONE M.D.</u>						22d. ADDRESS <u>3643 Glenridge Ave</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan 8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesa Chasos Chesa</u>			23d. LOCATION (City, town or county) (State) <u>Rondalltown, Md</u>				
24. FUNERAL DIRECTOR <u>Sol Lerman & Son</u>						ADDRESS <u>6010 Rust. Rd.</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JAN 11 1967</u>												

0300

71800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00318											
00321											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30.4</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shangri-La. Home 333 Harlem Lane</u>						d. STREET ADDRESS <u>429 S. Augusta Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>Klein</u> Last <u>Klein</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <u>Oct. 22, 1888</u>			9. AGE (In years last birthday) <u>78</u> yrs.			10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Charles F. Schnappinger</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Gischel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-20-8368</u>		17. INFORMANT <u>Mr. E. Melvin Klein 12 Magruder Ave. Catonsville</u>				Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u> <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>12 Year</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputated both legs August 1966 because of ulcers</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>67</u> , to <u>1/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>67</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>E. W. Johnson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>1/24/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. W. Johnson</u>						22d. ADDRESS <u>3432 Frederick Ave (29)</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>		
24. FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</u>						25a. REC'D BY REGISTRAR <u>JAN 26 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

19500

FOR STATE HEALTH DEPT.

00319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00322

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	c. LENGTH OF STAY IN lb 12 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 613 KINGSTON RD		d. STREET ADDRESS 613 KINGSTON RD	
3. NAME OF DECEASED (Type or print) SAMUEL ARDEN KNEPP First Middle Last		4. DATE OF DEATH JAN. 22 1967 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-26 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker	11. BIRTHPLACE (State or foreign country) Curwensville, Pa.
13. FATHER'S NAME Ira M. Knepp		14. MOTHER'S MAIDEN NAME Rilla Johnston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII & Korea		16. SOCIAL SECURITY NO. 178-20-7982	17. INFORMANT Address Mrs. Patricia C. Knepp same as 2D
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William A. Pillsbury		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> William M. 1-22-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-67	23c. NAME OF CEMETERY OR CREMATORY Crown Crest Cemetery
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		ADDRESS 1050 York Rd.	25a. REC'D BY REGISTRAR JAN 25 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00555

00310

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

ADJUTANT GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00320					00323									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY BALTIMORE					a. STATE MARYLAND									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE					b. COUNTY BALT									
c. LENGTH OF STAY IN 1b 3 days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE, WHITE MARSH									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTRE					d. STREET ADDRESS #1 BIRD RIVER GROVE RD.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE					
First Middle Last JOSHUA ELWOOD KNIGHT			Month Day Year JAN. 25 1967			M			W					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			IF UNDER 1 YEAR					
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8-18-1901			65 yrs.			Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILM EDITOR			10b. KIND OF BUSINESS OR INDUSTRY Mo. Censors			11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CLARENCE KNIGHT					14. MOTHER'S MAIDEN NAME HILDA BENTON									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 214-20-5063					17. INFORMANT Mrs Anna M. Knight Bird River Grove				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases</u> 162.1 DUE TO <u>Adenocarcinoma of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1967, to Jan. 25, 1967, that (I) (we) last saw the deceased alive on Jan. 25, 1967, and that death occurred at 10:15 M, from the causes and on the date stated above.														
22a. SIGNATURE M. MacGee					22b. DATE SIGNED 1-25-67									
22c. PHYSICIAN'S NAME (Type) M. MACGEE					22d. ADDRESS Greater Baltimore Med. Centre									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-28-1967									
23c. NAME OF CEMETERY OR CREMATORY Abingdon Cemetery					23d. LOCATION (City, town or county) (State) Abingdon Md.									
24. FUNERAL DIRECTOR Lassahn Funeral Home					25a. REC'D BY REGISTRAR DATE JAN 30 1967									
25b. REGISTRAR'S SIGNATURE Charles Judge														

00320

UNITED STATES OF AMERICA

00320

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES OF AMERICA" and "00320" are visible.]

FOR STATE
HEALTH DEPT.

00321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00324

1. PLACE OF DEATH o. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9 Patapsco Avenue		d. STREET ADDRESS 9 Patapsco Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN		Middle EDWARD		Last KOLB, Jr.	
4. DATE OF DEATH Month January		Day 1		Year 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH DOY 8, 1944		9. AGE (In years lost birthday) 22 yrs.		IF UNDER 1 YEAR Months 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY CITY BOARD OF ED.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DOAN E. KOLB, Sr.		14. MOTHER'S MAIDEN NAME FREDA MARTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-42-0112		17. INFORMANT FREDA M. KOLB, SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism 3220. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/1/67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/4/67		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL	
23d. LOCATION (City or Town) BEL AIR, MARYLAND		(County)		(State)	
24. FUNERAL DIRECTOR W. BROOKS BRADLEY, INC., DUNDALK		ADDRESS		25a. REC'D BY REGISTRAR JAN 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

00322

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00325

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 502 Forest Lane		d. STREET ADDRESS 502 Forest Lane	
3. NAME OF DECEASED (Type or print) Jeanne Elizabeth KREBS		4. DATE OF DEATH Month January Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-22
9. AGE (In years last birthday) yrs. 44.05		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vernon L. Knecht		14. MOTHER'S MAIDEN NAME Helen Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-16-3338	
17. INFORMANT Mr. Gerard Krebs 502 Forest Lane		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED January 12, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		25a. REC'D BY REGISTRAR JAN 16 1967	
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

00335

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RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO: SAC, HONOLULU
FROM: SAC, SAN FRANCISCO
SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOIA b (7) - FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department at Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANS DOWNE		c. LENGTH OF STAY IN 1b 20 YR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANS DOWNE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1714 HALL AVE 21227		d. STREET ADDRESS 1714 HALL AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERLINE BOWMAN KUHN		4. DATE OF DEATH Month JAN Day 2 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH NOV 20, 1910		9. AGE (In years lost birthday) yrs. 56		10. IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPRAY PAINTER		12. KIND OF BUSINESS OR INDUSTRY MFG.		13. BIRTHPLACE (State or foreign country) SMITHSBURG MD	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME ASA KUHN		16. MOTHER'S MAIDEN NAME JENNIE BOWMAN	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		18. SOCIAL SECURITY NO. 220163487		19. INFORMANT Address MRS. MARY GRACE KUHN SAME ADDRESS	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		21. INTERVAL BETWEEN ONSET AND DEATH			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
24a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
25a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		25b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
25d. (City or town)		25e. (County)		25f. (State)	
26. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		27. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 28. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 29. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6348 FREDERICK		30. DATE SIGNED 1/2/67	
31. ACTUAL SIGNATURE John N. Snyder M.D.		32. EXAMINER'S NAME (Type) JOHN N. SNYDER			
33a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		33b. DATE THEREOF 1/5/67		33c. NAME OF CEMETERY OR CREMATORY Blue Ridge	
33d. LOCATION (City or Town) Thurmont		33e. (County) Md.		33f. (State) Md.	
34. FUNERAL DIRECTOR Raymond E. Greager		34a. ADDRESS Thurmont, Md.		34b. REC'D BY REGISTRAR DATE JAN 5 1967	
34c. REGISTRAR'S SIGNATURE Charles Judge					

00336

RECEIVED BY THE DIRECTOR

00336

10-10-44



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00324

CERTIFICATE OF DEATH

00327

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 34 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 827 Hollins Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALFRED Middle JAMES Last LA LOTTE		4. DATE OF DEATH JANUARY 25 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <i>Separated</i> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/1/97
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William LaLotte	
14. MOTHER'S MAIDEN NAME Catherine Reynolds		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 217-05-93-66		17. INFORMANT Address Clinical Records, VA Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that xx (this hospital) attended the deceased from 12/22/ 19 66 to 1/25/ 19 67 , that xx (we) last saw the deceased alive on 1/25/ 19 67 , and that death occurred at 5:20A M, from causes and on the date stated above.	
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 1/25/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR John J. Cowan Funeral Home, Baltimore, Maryland	
25a. REC'D BY REGISTRAR St		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE JAN 26 1967			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any duty is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

00325

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00328

Item 9 Film G384 1/12/67 mh

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO-RURAL</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO-RURAL</u>			
c. LENGTH OF STAY IN lb <u>16 yrs.</u>				d. STREET ADDRESS <u>1842 YAKONA RD 34</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1842 YAKONA RD 34</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY (none) LANIGAN</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1883</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>8</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAND SCAPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NURSERY</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
13. FATHER'S NAME <u>DAVID LANIGAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ROLAND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>187-01-5689</u>		17. INFORMANT <u>Albert G. Lanigan</u> Address <u>1842 YAKONA RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcer</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John C. Hyle</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John C. Hyle</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-3-67</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/5/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	
23. FUNERAL DIRECTOR <u>William E. Johnson</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 1967</u>	
ADDRESS <u>8521 LOCH LAVER BLVD.</u>				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

00328

00328

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
003226					00329						
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN b. 23 mo' d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30.4 d. STREET ADDRESS 1915 W. Lombard St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Mary Margaret Lau			4. DATE OF DEATH Month Day Year 1 2 1967		9. AGE (In years last birthday) 29 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2.8.37		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph O'Halloran				14. MOTHER'S MAIDEN NAME Margaret Shanahan							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 216-34-3459		17. INFORMANT Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Empyema Thoracic Right.										INTERVAL BETWEEN ONSET AND DEATH 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2.10.1964 , to 1.2.1967 , that (I) (we) last saw the deceased alive on 1.2.1967 , and that death occurred at 11:48 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 1.2.67		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent					
22d. ADDRESS Mount Wilson, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 6 1967		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR Thomas J. Kenny, Inc 1600 Hollins St. Bal to. Md.				25a. REC'D BY REGISTRAR JAN 5 1967		25b. REGISTRAR'S SIGNATURE [Signature]					

00333

00333

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Mount Wilson State Hospital

Superintendent, Mount Wilson, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00327

CERTIFICATE OF DEATH

00331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 65 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2001 PENROSE AVENUE	
3. NAME OF DECEASED (Type or print) First STEPHEN Middle W. Last LeCRAFT		4. DATE OF DEATH Month JANUARY Day 12 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BAKERY	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 215 07 53 52	
17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 177X IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH METASTASES TO LIVER, LUNGS AND HIP BONES DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 11/18/66 , 19 66 , to 1/12/67 , 19 67 , that he (we) last saw the deceased alive on 1/12/67 , 19 67 , and that death occurred at 9:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Howard C. Kramer		22b. DATE SIGNED 1/12/67	
22c. PHYSICIAN'S NAME (Type) HOWARD C. KRAMER, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/16/1967	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR HAYES FUNERAL HOME	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 17 1967 638 N. Gilmore St. Balto. Md.	

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GRANTHAM, GRANGE, GRAY, GRAY

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00330

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BALTIMORE

BALTIMORE

BALTIMORE

BALTIMORE

810 BEAL'S COURT

810 BEAL'S COURT

WILSON

WILSON

WHITE

WHITE

HOUSE

HOUSE

WILLIAM ELLISON

WILLIAM ELLISON

HOME

MRS. DORIS L. GORE

NO

Handwritten notes:
MRS. DORIS L. GORE
810 BEAL'S COURT

WILSON

WILSON

WILSON

00329

CERTIFICATE OF DEATH

00332

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 30.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21214 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21214 d. STREET ADDRESS 6113 Tramore Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last LEE		4. DATE OF DEATH Month January Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1903
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bauman		14. MOTHER'S MAIDEN NAME Mary Lohman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-2584	
17. INFORMANT Mrs. Cynthia Rohde		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardio-Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Obstruction of the Pulmonary Conus by Mural DUE TO (c) Thrombus in Right Ventricle		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/9/ , 19 66 , to 1/20/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/20/ , 19 67 , and that death occurred at 1:30PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Reynaldo Orjuela-Gomez M.D.		22b. DATE SIGNED January 20, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Reynaldo Orjuela-Gomez M.D.		22d. ADDRESS 6720 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/67	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR JAN 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5580

00359

FOR STATE
HEALTH DEPT.

00330

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00333

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kennedy Hwy. near White Marsh Blvd.		d. STREET ADDRESS 364 Lamokin St.	
3. NAME OF DECEASED (Type or print) First Lorenzo Middle Lee Last Lee		4. DATE OF DEATH Month 1 Day 21 Year 19 67	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH march 11 1944
9. AGE (In years lost birthday) yrs. 22		10. IF UNDER 1 YEAR Months 03 Days 11	11. IF UNDER 24 HRS. Hours 08 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY n.e.	
11. BIRTHPLACE (State or foreign country) n.e.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alton Roberta		14. MOTHER'S MAIDEN NAME Alberta Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alberta Perry Williamson n.e.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 819.4 IMMEDIATE CAUSE (a) Multiple injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto into fixed object	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:46 xxx 1 21 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> ot work <input type="checkbox"/> ot work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 1/21/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-26-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY See cem		23d. LOCATION (City or Town) (County) (State) Williamston n.e.	
24. FUNERAL DIRECTOR Geo. W. Nelson 1348 n. Calhoun St		25a. REC'D BY REGISTRAR JAN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00333

00330

COPIES

FOR STATE
HEALTH DEPT.

00331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00334

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kennedy Hwy. nr. White Marsh Blvd.		d. STREET ADDRESS 6147 Spruce St.	
3. NAME OF DECEASED (Type or print) Louis Lee		4. DATE OF DEATH Month 1 Day 21 Year 19 67	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-26
9. AGE (In years lost birthday) yrs. 40		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) n.c.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Romus Lee		14. MOTHER'S MAIDEN NAME Alice Knight	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alberta Perry Williamson n.c.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver of auto into fixed object	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:46 xx 1 21 19 67	20d. INJURY OCCURRED 2 While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz M.D.		22. DATE SIGNED 1/21/67	
EXAMINER'S NAME (Type) Werner U. Spitz		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-26-67	23c. NAME OF CEMETERY OR CREMATORY Lee Cem	23d. LOCATION (City or Town) (County) (State) Williamston n.c.
24. FUNERAL DIRECTOR Leo S. Nelson 1348 n. Calhoun St		25a. REC'D BY REGISTRAR JAN 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00334

00334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00332					00335				
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21213 d. STREET ADDRESS 1711 N. Freedomway Balt. 13, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Paul (Paolo) LETRA					4. DATE OF DEATH Month Day Year Jan. 29 1967				
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 84 6-25-84		9. AGE (In years last birthday) 82 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Geatano Letra					14. MOTHER'S MAIÖEN NAME ? Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-07-2922		17. INFORMANT Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis with undetermined Origin								INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-20, 1967 to 1-29, 1967 , that (I) (we) last saw the deceased alive on 1-29, 1967 , and that death occurred at 2:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-29-67			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balt. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00332

00332

Baltimore County

Mount Wilson

Mount Wilson State Hospital

and

Unknown

Records of Mount Wilson State Hospital

Superintendent, Mount Wilson, Maryland

July 1900, Baltimore, Md.

Mount Wilson State Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00333					00336				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>13.1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>					d. STREET ADDRESS <u>3301 Timberfield Lane #8</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Samuel</u>		Middle		Last <u>Liberman</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 19, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-3241</u>		17. INFORMANT Address <u>Mrs. Tina Liberman, 3301 Timberfield Lane</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary Tract infection</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>66</u> , to <u>1-9</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>1-9</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>David J. Miller</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-9-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David J. Miller</u>				22d. ADDRESS <u>Linson Rd. Owings M. 16 Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. Inc., 6010 Reisterstown Rd.</u>				25a. REC'D BY REGISTRAR <u>16</u> 19 <u>67</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00334

CERTIFICATE OF DEATH

00337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>30.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21214</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		d. STREET ADDRESS <u>2715 Beechland Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Lidinsky</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bureau of Parks</u>		12. KIND OF BUSINESS OR INDUSTRY <u>City of Baltimore</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Frank Lidinsky</u>		16. MOTHER'S MAIDEN NAME <u>Mary Hora</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		18. SOCIAL SECURITY NO. <u>217-16-4512</u>	
19. INFORMANT <u>Mrs. Mary A. Lidinsky</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1919</u> IMMEDIATE CAUSE (a) <u>Metastatic Cancer (squamous cell)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (it) (this hospital) attended the deceased from <u>Jan. 2</u> , 19 <u>67</u> , to <u>Jan. 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 9</u> , 19 <u>67</u> , and that death occurred at <u>5.45 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ramon P. Lopez</u>		22b. DATE SIGNED <u>1/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ramon P. Lopez</u>		22d. ADDRESS <u>7620 York Rd. Baltimore, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/13/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00335						00338					
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				d. STREET ADDRESS <u>614 NORTHBEND RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>614 NORTHBEND RD</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SARAH</u>			First Middle Last			4. DATE OF DEATH <u>JAN 9 1967</u>			Month Day Year		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-1882</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JOHN G SHAW</u>						14. MOTHER'S MAIDEN NAME <u>AMELIA WAIDNER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>WALTER LINTHICUM 614 NORTHBEND RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic cardio vascular disease</u> (c) <u>disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>Jan 6</u> , to <u>Jan 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> , 19 <u>67</u> , and that death occurred at <u>3</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Harmon U. Todd</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Harmon U. Todd</u>						22d. ADDRESS <u>2108 St Paul St</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-11-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>		23d. LOCATION (City, town or county) (State) <u>FREDERICK RD MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>WEBER FUNERAL HOME 5312 EDMONDSON AVE</u>						25a. REC'D BY REGISTRAR <u>JAN 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item 7 Film G384 1/18/67 mh													
00336													
CERTIFICATE OF DEATH													
Item 2b Film G385 1/24/67 mh													
00339													
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u> ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSTOCK</u> 13.2							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RIDGEWAY MANOR</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PETER N. LIVESAY</u> First Middle Last						4. DATE OF DEATH Month <u>JAN.</u> Day <u>9</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-9-1895</u> <u>TH</u>		9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LEE Co. VA.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JEFF LIVESAY</u>						14. MOTHER'S MAIDEN NAME <u>ADELINE PEARSON</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>226-16-2492</u>		17. INFORMANT <u>Robert Bryant</u>				Address <u>Woodstock Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4/4</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4 Jan</u> , 19 <u>67</u> , to <u>9 Jan</u> , 19 <u>67</u> that (I) (we) las saw the deceased alive on <u>9 Jan</u> 19 <u>67</u> , and that death occurred at <u>257 PM</u> , from causes and on the date stated above													
22a. SIGNATURE <u>William Goodman, M.D.</u>						22b. DATE SIGNED <u>10 Jan 67</u>				22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u>			
22d. ADDRESS <u>1334 Kuhlman Sq Rd 21227</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>1-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Baptist</u>				23d. LOCATION (City or Town) (County) (State) <u>Glenwood Md.</u>			
24. FUNERAL DIRECTOR <u>F.C. HIGGINBOTHAM, ELLICOTT CITY, MD.</u>						25a. REC'D BY REGISTRAR <u>DATE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00337

CERTIFICATE OF DEATH

00340

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 1 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Teresa Middle Lee Last LOCKWOOD			4. DATE OF DEATH Month 1 Day 17 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-64	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 1 Days 17 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Cecil Co., Maryland	
13. FATHER'S NAME John Howard Lockwood			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe mental retardation					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-19- 19 65 , to 1-17- 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-17 19 67 , and that death occurred at 9:15 A.M. causes and on the date stated above.					
22a. SIGNATURE Zsolt Koppanyi			22b. DATE SIGNED 1-17-68		
22c. PHYSICIAN'S NAME (Type) Zsolt Koppanyi, M.D.			22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Jan 20 1967	23c. NAME OF CEMETERY OR CREMATORY Basic Cemetery		23d. LOCATION (City or Town) (County) (State) Normal Barclay Commemorative Co.
24. FUNERAL DIRECTOR Edward Fellows			25a. REC'D BY REGISTRAR Williamington, Md.		
25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JAN 20 1967		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00338

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00341

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) <u>HARRISONVILLE</u>				c. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u> <u>03.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CHAPEL HILLS NURSING HOME</u>				d. STREET ADDRESS <u>Dover Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Marian</u> Middle <u>Carney</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1, 1895</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Albert P. Carney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Chenoweth</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Copious thrombus (massive)</u> <u>350X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>hypertension + arteriosclerosis</u> DUE TO (c) <u>Parkinson disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>✓</u>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>✓</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-40</u> , 19 <u>40</u> to <u>1-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-24</u> , 19 <u>66</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James G. Saffell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>				22d. ADDRESS <u>Reisterstown</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Falls Rd. Meth. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR <u>1-13-1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00394

08341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore Co.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>32 1/2 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21236</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>						d. STREET ADDRESS <u>4240 THORNCLIFF RD.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRENE ANN LOTT</u>						4. DATE OF DEATH Month Day Year <u>JANUARY 8 1967</u>					
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-05</u>		9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INS. EXAMINER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PATERSON, N.J.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Foley</u>						14. MOTHER'S MAIDEN NAME <u>LILLIAN Ann QUINN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNK 217-261802</u>		17. INFORMANT Address <u>PT. CHART Mary Ann Kraus 8711 Belair Rd 36</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic adenocarcinoma of mediastinum</u> DUE TO (c) <u>Probably Carcinoma of the Lung</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/7/</u> , 19 <u>67</u> , to <u>1/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/8</u> , 19 <u>67</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Juan L. Roque</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>1-8-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>						22d. ADDRESS <u>6701 N. Charles St. Balto 4 Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>						25a. REC'D BY REGISTRAR <u>(34)</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>JAN 10 1967</u>											

00339

00339

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00343

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b ESSEX 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 623 FRANKLIN		d. STREET ADDRESS 623 FRANKLIN	
3. NAME OF DECEASED (Type or print) ROY LOWERS		4. DATE OF DEATH Month JAN Day 30 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 26 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 75
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SAM B. LOWERS		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO. —	
17. INFORMANT LOWERS		Address 623 FRANKLIN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous CVA			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo C. Patterson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) THEO C. PATTERSON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 1/30/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 1/30/67	23c. NAME OF CEMETERY OR CREMATORY ST. PAULS LUTHERAN	23d. LOCATION (City or Town) (County) (State) NORVELT PA
24. FUNERAL DIRECTOR J.F. CONNELLY SONS		25a. REC'D BY REGISTRAR 300 MACE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Hypodermis (Dermatophyte)

Genus CVA

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Genus CVA

1955

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00341

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00344

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>113 DAYS</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Balto. Medical Center</i>		d. STREET ADDRESS <i>65 Garden Ridge Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>FANNIE</i> Middle <i>LOWRY</i> Last <i>LOWRY</i>		4. DATE OF DEATH Month <i>1</i> Day <i>16</i> Year <i>1967</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/21/86</i>	9. AGE (In years last birthday) <i>80</i> yrs.	IF UNDER 1 YEAR Months <i>8</i> Days <i>16</i> Hours <i>19</i> Min. <i>28</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NH</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NA</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Balto. MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Albert Miller</i>		14. MOTHER'S MAIDEN NAME <i>Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-0378</i>		17. INFORMANT <i>Patient's Chart</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>465X Pulmonary Embolus leading to Cardiovascular Collapse</i> DUE TO (b) <i>to Cardiovascular Collapse</i> DUE TO (c) <i>465X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>48h.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Gall Bladder with perforation</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-3-</i> , 19 <i>67</i> , to <i>1-16</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1-16</i> , 19 <i>67</i> , and that death occurred at <i>5:35 AM</i> from the causes and on the date stated above.		22a. SIGNATURE <i>R K Chhillar</i>		22b. DATE SIGNED <i>1-16-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>RAM K. CHHILLAR</i>		22d. ADDRESS <i>6th. BALTIMORE MED. CENTER BALTIMORE, MD. 21204.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1-19-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LORRAINE PARK Cem.</i>	
23d. LOCATION (City, town or county) (State) <i>Woodlawn Maryland</i>		24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson Inc</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>JAN 19 1967</i>			

00354

00354

Ram E. CHILLER

William

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GM. BARTON AND CO.

1-11-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH			
00342				00345			
1. NAME OF DECEASED (Type or Print) LUKOSZEWICZ, KONSTANTIN				2. DATE AND HOUR OF DEATH 1/2/67 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTIMORE COUNTY				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 30.4			
5. FULL NAME OF HOSPITAL OR INSTITUTION CATON RIDGE NURSING HOME				6. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD 21229			
7. STREET ADDRESS (If rural, give location) 329 HARLEM LANE				8. D. STREET ADDRESS (If rural, give location) 329 HARLEM LANE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2-2-86	9. AGE (In years last birthday) 80	10. If Under 1 Yr. Months Days	11. If Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger				10B. KIND OF BUSINESS OR INDUSTRY Self-Employed			
11. BIRTHPLACE (State or foreign country) LITHUANIA				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME ZANON LUKOSZEWICZ				14. MOTHER'S MAIDEN NAME EVA PASKAVICH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. ?			
17. INFORMANT CHART				ADDRESS Alone			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 154X				CAUSE OF DEATH (A) Intermittent cardiac disease DUE TO cardiac disease (B) ADENOCARCINOMA OF DUE TO RECTUM. (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 154X				INTERVAL BETWEEN ONSET AND DEATH			
22. I certify that (I) (this hospital) attended the deceased from April 28 19 66 to Jan 2 19 67 that (I) (we) last saw the deceased alive on Dec. 30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Kasaitis M.D.				23B. DATE SIGNED 1/2/67			
23C. PHYSICIAN'S NAME (Type) E. KASAITIS,				23D. ADDRESS 1801 FREDERICK RD #28			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/67		24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery		24D. LOCATION (If new, or county) (State) Ritchie Hwy. No.	
25A. DATE REC'D BY HEALTH DEPT. JAN 9 1967		25B. NAME OF REGISTRAR John F. Bowman		25C. FUNERAL DIRECTOR John F. Bowman		ADDRESS 101 E. Hollins	

25590

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00343

CERTIFICATE OF DEATH

00346

1. PLACE OF DEATH o. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERIA BEACH		022	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 258 KENWOOD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM		Middle JOSEPH		Last LYNCH		4. DATE OF DEATH Month JANUARY	
						Day 28	
						Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 16, 1919		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4
						Days 19	
						Hours 67	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE WORKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH LYNCH				14. MOTHER'S MAIDEN NAME AMADA PICARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 005 07 83 39		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE						INTERVAL BETWEEN ONSET AND DEATH DAYS	
581-1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) LAENNEC'S CIRRHOSIS						YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DELIRIUM TREMENS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that IV (this hospital) attended the deceased from JAN. 24 , 19 67 , to JAN. 28 , 19 67 , that IV (we) last saw the deceased alive on JAN. 28 , 19 67 , and that death occurred at 1125A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Paulino D. Deocampo</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-28-67	
22c. PHYSICIAN'S NAME (Type) PAULINO D. DEOCAMPO, M.D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL (entombment)		23b. DATE THEREOF 1/31/67		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) WOODLAWN, MARYLAND	
24. FUNERAL DIRECTOR LEONARD J. RUCK INC.				25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
5305 HARFORD RD., BALTIMORE, MARYLAND							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00344			CERTIFICATE OF DEATH				00347				
Item 2 Film Q385 1/24/67											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. LENGTH OF STAY IN 1b <i>2 Days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 21229</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Greater Baltimore Med. Center</i>					d. STREET ADDRESS <i>4151 Choptank Rd.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>May</i> Last <i>Maben</i>			4. DATE OF DEATH Month <i>1</i> Day <i>14</i> Year <i>1967</i>								
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/4/18</i>		9. AGE (In years last birthday) <i>49</i> Yrs.			
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Thomas Laughlin</i>					14. MOTHER'S MAIDEN NAME <i>Albie Lloyd</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Unknown</i>			16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic vascular</i> (c) <i>disease.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 14th, 1967</i> to <i>Jan. 14th, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan. 14th, 1967</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>W. I. MacGregor</i>								22b. DATE SIGNED <i>1-14-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>W. I. MacGregor</i>								22d. ADDRESS <i>Greater Baltimore Medical Center</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1-18-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louisa</i>			23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson, Towson, Md.</i>					25a. REC'D BY REGISTRAR <i>JAN 19 1967</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

00347

00348



00345

CERTIFICATE OF DEATH

00348

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women's + Aged Men's Home</u>				d. STREET ADDRESS <u>3114 Kentucky Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>E</u> Last <u>Maguire</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1878</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard, Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Maguire</u>		14. MOTHER'S MAIDEN NAME <u>Edith Updegraff</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-52-2928</u>		17. INFORMANT <u>A.M. Weaver - Pickersgill</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25</u> , 19 <u>59</u> , to <u>Jan. 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 25</u> , 19 <u>67</u> , and that death occurred at <u>4 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Newland E. Day</u>				22b. DATE SIGNED <u>January 24, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Newland E. Day</u>				22d. ADDRESS <u>4-E-33rd St Balto. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc.</u>				ADDRESS <u>1050 York Rd.</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

2490

2330

Accepted: 12/1/2003

402A

Wednesday 8. Day

8-8722-EE-3-4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00347					00350					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Baltimore					a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk					b. COUNTY Baltimore					
c. LENGTH OF STAY IN ID 38 years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6915 Dunmanway					d. STREET ADDRESS 6915 Dunmanway					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year		
MARTIN JOSEPH MALEY, Jr.,						January 28, 1967				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1910		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die Maker			10b. KIND OF BUSINESS OR INDUSTRY Steel Mfr.			11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin J. Maley, Sr.,					14. MOTHER'S MAIDEN NAME Kathryn Barrett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-07-9197		17. INFORMANT Dolores Maley, Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction due to Coronary Artery Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis, H. Middle cerebral artery INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1967, to Jan 28, 1967, that (I) (we) last saw the deceased alive on Jan 20, 1967, and that death occurred at 1:25 PM, from the causes and on the date stated above.										
22a. SIGNATURE Paul G. Koukoulas					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/30/67		
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS MD					22d. ADDRESS 6511 O'Donnell Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/1/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cmty.			23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.					25a. REC'D BY REGISTRAR DATE FEB 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

00334

00330

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Age	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Registrar		Signature of Medical Officer	
Signature of Coroner		Signature of Police Officer	
Signature of Burial Officer		Signature of Cemetery Officer	
Signature of Undertaker		Signature of Funeral Director	
Signature of Minister of Religion		Signature of Other	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

00346

#12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00349

1. PLACE OF DEATH a. COUNTY Towson BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 2807 Chesley Ave.	
3. NAME OF DECEASED (Type or print) First Laura Middle Malinowski Last Malinowski		4. DATE OF DEATH Month 1 Day 8 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 22, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78 77/8
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Swincinski		14. MOTHER'S MAIDEN NAME Felicia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio Renal Vascular Disease DUE TO 10 yrs (c) Diabetes Mellitus 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 11/2/67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City or Town) (County) (State) AA Co Md
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR DATE JAN 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00348				CERTIFICATE OF DEATH				00351					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Baltimore 21224									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forest Haven Nursing Home, Inc.				d. STREET ADDRESS 7406 Belmont Ave. 315 Ingleside Ave. 03-1									
3. NAME OF DECEASED (Type or print) HENRY F. MAROTZ				4. DATE OF DEATH January 20 19 67				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1890		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Nelson Box Co.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Julius Marotz				14. MOTHER'S MAIDEN NAME Sophia Maisenhalder									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-09-2124				17. INFORMANT Address A.- Anna H. Ortel 7819 Wynbrook Rd. #24					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROSIS Cerebro-vascular disease & Myocardial infarction DUE TO SEVERE ARTERIAL DUMBER - SPINAL DUE TO SPINAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2/1/67 to 1/20/67 , 19 67 , that (I) (we) last saw the deceased alive on 1/10/67 , 19 67 , and that death occurred at 11 PM , from the causes and on the date stated above.													
22a. SIGNATURE John H. Shaw				22b. DATE SIGNED 1/23/67				22c. PHYSICIAN'S NAME (Type) JOHN H. SHAW					
22d. ADDRESS 5800 Edmondson Ave. Balto., Md													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-23-67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d. LOCATION (City, town or county) (State) 7225 Eastern Blvd. Ba. Co. Md					
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jailer				ADDRESS 6224 Eastern Ave. Baltimore, 21224, MD.				25a. REC'D BY REGISTRAR DATE JAN 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00349
Item 8 Film G384 1/12/67 mh
00352

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>4105 Essex Rd. Pikesville</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Katherine Robb Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Glorcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pitman</u> d. STREET ADDRESS <u>216 Boulevard</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>McLarrick</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14 1877</u> AGE (In years last birthday) <u>95</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia Pa</u>
13. FATHER'S NAME <u>William Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Anne Morgan Pikesville</u>		Address <u>4215 Melford Mill Rd. Baltimore Md 21207</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>Arteriosclerosis, generalized.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sep 17</u> , 19 <u>67</u> to <u>Jan 10</u> , 19 <u>67</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>Dec 19</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul H Royse</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE</u>		22d. ADDRESS <u>1403 Foley Lz. Baltimore, Md. 21205</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Phila Pa.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell & Corp</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Pikesville, Md.</u>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00350

CERTIFICATE OF DEATH

00353

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 48 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 4809 ALTHEA AVENUE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MATTHEW Middle L. Last MC CARTER		4. DATE OF DEATH Month 1/10/67 Day 19 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 80 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATTHEW MC CARTER		14. MOTHER'S MAIDEN NAME ELIZABETH CLARK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212 26 30 24	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CARCINOMA OF RECTUM DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH RECENT & OLD UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from 11/23/66 , 19__ to 1/10/67 , 19__, that he (we) last saw the deceased alive on 1/10/67 , 19__, and that death occurred at 6:45 AM from causes and on the date stated above.			
22a. SIGNATURE George C. McElPatrick, M.D.		22b. DATE SIGNED 1/10/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. McELPATRICK, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/12/67	
23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Leonard J. RUCK		25a. REC'D BY REGISTRAR JAN 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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404 ALBANY AVENUE

REVENUE

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REVENUE ADMINISTRATION

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FOR STATE
HEALTH DEPT.

00351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00354

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		c. LENGTH OF STAY in lb 3 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 406 FOX CHAPEL DRIVE		d. STREET ADDRESS 406 FOX CHAPEL DRIVE	
3. NAME OF DECEASED (Type or print) ROY First EDWARD Middle McDANIEL Last		4. DATE OF DEATH Month JAN Day 3 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASS. MANAGER		10b. KIND OF BUSINESS OR INDUSTRY HUMBLE OIL & REFINING CO.	9. AGE (In years last birthday) 61 yrs.
11. BIRTHPLACE (State or foreign country) VANCEBURG, KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY GRANT McDANIEL		14. MOTHER'S MAIDEN NAME SUDIE CLARK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 234-10-7486	
17. INFORMANT Mrs. MARY E. McDANIEL		Address 406 FOX CHAPEL DR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, county, state) Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/7/68	23c. NAME OF CEMETERY OR CREMATORY GREENBRIER BURIAL PARK	23d. LOCATION (City or Town) (County) (State) HINTON, W. VA.
24. FUNERAL DIRECTOR Wm. COOK-BROOKS TOWSON		25a. REC'D BY REGISTRAR 1050 YORK RD 21204	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00352

CERTIFICATE OF DEATH

00355

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lyrllmth2ldys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 7510 Wellesley Drive	
3. NAME OF DECEASED (Type or print) Charles Nimrod McDevitt		4. DATE OF DEATH Month January Day 3 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1888
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles A. McDevitt		14. MOTHER'S MAIDEN NAME Flora Whalen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-4899	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Acute heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infected ulcers of buttocks			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____ of work _____	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>Jan. 12, 1965</u> to <u>Jan. 3, 1967</u> that (x) (we) last saw the deceased alive on <u>Jan. 3, 1967</u>, and that death occurred at <u>2:55</u> M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 1-3-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/6/67	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) ST. PETERSBURG, FLA.
24. FUNERAL DIRECTOR E. S. Mac Nabb		25a. REC'D BY REGISTRAR DATE JAN 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 301 Frederick Rd Baltimore, MD #28	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00353					00356				
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Guilford					d. STREET ADDRESS Guilford				
3. NAME OF DECEASED (Type or print) ELIZABETH SUSAN MC DONALD					4. DATE OF DEATH Month Jan. Day 25 Year 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1895		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19		11. IF UNDER 24 HRS. Hours 6 Min. 43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ezrael Funk			14. MOTHER'S MAIDEN NAME Amanda Whitmore						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-12-1030		17. INFORMANT Louis Mc Donald, P.O. Box 124, Daniels, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE 6 HRS 10 YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PYELONEPHRITIS									
19. INTERVAL BETWEEN ONSET AND DEATH 6 HRS									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-23 , 1957, to 1-28 , 1967, that (I) (we) last saw the deceased alive on 1-18 , 1967, and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE V. V. H. H.					22b. DATE SIGNED 1-26-67			22c. PHYSICIAN'S NAME (Type)	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-28-1967		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City, town or county) (State) Ellicott City, Md		
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md					25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00354

CERTIFICATE OF DEATH

00357

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor		d. STREET ADDRESS 904 Wellington Rd.	
3. NAME OF DECEASED (Type or print) Harold Paul McEntee		4. DATE OF DEATH Month Jan. Day 19 Year 67	
5. SEX M.	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditing		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.Co.	9. AGE (In years lost 69 day) yrs. 69
11. BIRTHPLACE (County & State, or foreign country) Covington, Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McEntee		14. MOTHER'S MAIDEN NAME Ida Mae Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Dorothy McEntee, 904 Wellington Rd.		18. ADDRESS Baltimore, Md. 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 163X Carcinoma of lung IMMEDIATE CAUSE (a) 163X DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 8, 1967 to 1/19, 1967 that (I) (we) last saw the deceased alive on 1/18, 1967 , and that death occurred at 7:50 A.M. from causes on and on the date stated above.			
22a. SIGNATURE William Fr. Fritz		22b. DATE SIGNED 1/20/67	
22c. PHYSICIAN'S NAME (Type) William Fr. Fritz		22d. ADDRESS 2 West University Pkwy, Baltimore 21218	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-23-67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City or Town) (County) (State) Woodlawn, Baltimore, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE JAN 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TESTIMONY OF

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00355

Item #2c & d Film #G386 3/20/67 pc

CERTIFICATE OF DEATH

00358

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Cecil Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 2yrs8ms.5dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. New Market Elkton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 265 Mackall St. Springdale Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle (McKinney) Last McKenney				4. DATE OF DEATH Month Jan. Day 24 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892 10-7-1891	
9. AGE (In years lost birthday) yrs. 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) ELK NECK, MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES M. JONES				14. MOTHER'S MAIDEN NAME MARGARET E. DAVIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-54-3233		17. INFORMANT Address Records: Spring Grove State Hospital			
<div style="writing-mode: vertical-rl; transform: rotate(180deg); position: absolute; left: -40px; top: 50%; font-weight: bold;">MEDICAL CERTIFICATION</div> <div> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, generalized DUE TO (b) volvulus DUE TO (c) megacolon and fecal impaction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 570.3 </div> <div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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210-1-1233 Belmont: Spring Grove State Hospital

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00359

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesaco Park		c. LENGTH OF STAY IN lb Chesaco Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 351 Potomac Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK GUY McMILLEN		4. DATE OF DEATH Month Day Year January 7, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years birthday yrs.) 77
11. BIRTHPLACE (State or foreign country) Kitzmiller, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Elsworth McMillen		14. MOTHER'S MAIDEN NAME Luella Milles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-18-5227	
17. INFORMANT Rev. C.W. Whalen, 351 Potomac Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Hypertensive Cardiovascular (b) disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson		M.D.	
EXAMINER'S NAME (Type) Dr. Theodore C. Patterson, M.D.		22. DATE SIGNED 1/7/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION (City or Town) (County) (State) Elkins, West Virginia	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE JAN 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

00357

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN tb 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangrila Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle L. Last MEEKS		4. DATE OF DEATH Month January Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1881
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Joseph Trader		14. MOTHER'S MAIDEN NAME Lucretia Margaret Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-8333 D	
17. INFORMANT Miss Janet L. Meeks		Address same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Right Acute Pyelonephritis. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 1/15/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/17/1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. F. Finken & Sons		25a. REC'D BY REGISTRAR JAN 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00358

Item 23b Film G385 2/6/67 mh

CERTIFICATE OF DEATH

00361

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1621 RICKENBACKER ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY JOHN MELL				4. DATE OF DEATH Month JANUARY Day 29 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 14, 1891	
9. AGE (In years lost birthday) yrs. 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		11. BIRTHPLACE (County & State, or foreign country) FULTON COUNTY, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM MELL				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 213 07 5587		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBSTRUCTIVE EMPHYSEMA							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN. 22 , 19 67 , to JAN. 29 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JAN. 29 , 19 67 , and that death occurred at 11:05 P.M. , from causes and on the date stated above.							
22a. SIGNATURE <i>J. D. Talbert</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1 30 67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Connelly Funeral Home 300 Mace Ave. Baltimore 21, Md.				25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00359

CERTIFICATE OF DEATH

00362

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #34		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3108 DuBois Avenue				d. STREET ADDRESS 3108 DuBois Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH First Middle Last				4. DATE OF DEATH January 13, 1967 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1888	
9. AGE (In years last birthday) yrs. 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph P. Sweglar				14. MOTHER'S MAIDEN NAME Judith T. Murphy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-0885B		17. INFORMANT Mr. Ernest L. Menefee, Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Carcinomatous DUE TO (b) Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							INTERVAL BETWEEN ONSET AND DEATH 4 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 67 , to 1/13 , 19 67 that (I) (we) lost the deceased alive on 1/13 , 19 67 , and that death occurred at 2:45 M, from causes on and on the date stated above.							
22a. SIGNATURE Harold H. Burns M.D.				22b. DATE SIGNED 1-16-67		22c. PHYSICIAN'S NAME (Type) Harold H. Burns	
22d. ADDRESS 8106 Harford Rd.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/18/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE JAN 18 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00352

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00360

CERTIFICATE OF DEATH

Item 0 Film 4305 2/3/67 mh

00363

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY in 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 6902 Petworth Est Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIE Middle BOND Last MERRITT		4. DATE OF DEATH Month 1 Day 26 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-87 1877
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House worker		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Bond		14. MOTHER'S MAIDEN NAME Seamons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT A. BOND MERRITT, 609 OVERBROOK Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 434/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure. Pulmonary edema (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-17 , 19 67 , to 1-26 , 19 67 , that (I) (we) last saw the deceased alive on 1-26 , 19 67 , and that death occurred at 3:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE Juan L. Roque		22b. DATE SIGNED 1/26/1967	
22c. PHYSICIAN'S NAME (Type) JUAN L. ROQUE		22d. ADDRESS 6BMC, Balto 4.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THERE 1/30/1967	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City, town or county) (State) Balto Co. Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR J. Charles Judge 25b. REGISTRAR'S SIGNATURE	
DATE JAN 27 1967			

00363

00363

Baltimore

Maryland

Baltimore

First National Bank of Baltimore
Baltimore, Md.
Baltimore, Md.

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Baltimore, Md.

CERTIFICATE OF DEATH

00361

00364

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Hospital</u>				d. STREET ADDRESS <u>344 East 23 1/2 Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>-</u> Last <u>MICKENS</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/53</u>		9. AGE (In years last birthday) <u>13</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Mickins</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Logan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Rosewood Records, Owings Mills, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>7531</u> DUE TO (b) <u>Terminal Myoclonic Seizure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Multiple Congenital Abnormalities of Brain</u> DUE TO (c) <u>14 yr</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Terminal</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 23, 1958</u> to <u>Jan 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 17, 1967</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Harvey M. Solomon</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harvey M. Solomon, M.D.</u>				22d. ADDRESS <u>ROSEWOOD STATE HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Owings Mills, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>				ADDRESS <u>Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 30 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00300

00301

CERTIFICATE OF DEATH

*Multiple Congestive Heart Failure
of Senile Type*

FOR STATE
HEALTH DEPT.

00362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00365

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs HOSPITAL Hospital		d. STREET ADDRESS 913 Dulaney Valley Court	
3. NAME OF DECEASED (Type or print) EDWARD J. MILLER JR.		4. DATE OF DEATH Month Jan. Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1897
9. AGE (In years birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Sales Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Newspaper Advertising	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward J. Miller Sr.		14. MOTHER'S MAIDEN NAME Marion (not known)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. WW-1	
17. INFORMANT Edw. J. Miller 111		18. ADDRESS 204 Brackenwood Court Lutherville, Md. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure DUE TO Overdose of Librium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and Alcohol DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 1/10/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-67	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a. REC'D BY REGISTRAR JAN 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00362

00362

(not known)

(not known)

70-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00366

00363

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NURSING HOME</u>		d. STREET ADDRESS <u>5218 Gwynndale Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2, 1877</u>
9. AGE (In years lost birthday) yrs. <u>89</u>		IF UNDER 1 YEAR Months <u>03</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ERASTES FOGG</u>		14. MOTHER'S MAIDEN NAME <u>RACHEL FOGG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-54-8108</u>	
17. INFORMANT <u>Mrs. Eva E. OLIVERIO</u>		Address <u>SAME AS 2-d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease.</u> DUE TO (c) <u>DISEASE.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 months.</u> <u>5 months.</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(3) Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/9/66</u> to <u>1/4/67</u> , that (I) met last saw the deceased alive on <u>1/3/67</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W E Mc Grath</u>		22b. ADDRESS <u>1303 Frederick Rd Catonsville</u>	
22c. PHYSICIAN'S NAME (Type) <u>W E Mc Grath</u>		22d. ADDRESS <u>1303 Frederick Rd Catonsville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Jan. 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury Sr.</u>		25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1 *26*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

27

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00364

CERTIFICATE OF DEATH

00367

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 30.4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 61 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 2664 FLORA STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS W MILLS		4. DATE OF DEATH Month Day Year JANUARY 8 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-24
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE MILLS		14. MOTHER'S MAIDEN NAME Luvenia Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 217 12 81 70	
17. INFORMANT CLINICAL RECORDS, VAH. FT. HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS WITH INVASION OF MEDIASTINUM DUE TO (b) 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 11/3/66 , 19 to 1/8/67 , 19, that (we) last saw the deceased alive on 1/8/67 , 19, and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 1/9/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-12-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MARSHALL JONES		25a. REC'D BY REGISTRAR DATE JAN 10 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00365					CERTIFICATE OF DEATH			00368	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 30.4				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS 909 S. CHARLES STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last MITCHELL					4. DATE OF DEATH Month JANUARY Day 10 Year 19 67				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 5, 1914		9. AGE (In years last birthday) yrs. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER			10b. KIND OF BUSINESS OR INDUSTRY CONTRACTING		11. BIRTHPLACE (County & State, or foreign country) SHEPHERDSTOWN, W. VA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILL MITCHELL					14. MOTHER'S MAIDEN NAME LAURA SHANNON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 232 26 74 80		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM DUE TO (b) ARTERIOSCLEROTIC CORONARY THROMBOSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JAN 9 , 19 67 , to JAN 10 , 1967, that (I) (we) last saw the deceased alive on JAN 10 , 19 67 , and that death occurred at 1000 A. M, from causes and on the date stated above.									
22a. SIGNATURE J. D. Talbert MD M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 1/10/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.					22d. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-13-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR ZANNINO FUNERAL HOME 257 S. Conkling St. Baltimore, Maryland					25a. REC'D BY REGISTRAR DATE JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00366					00369				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
baltimore					Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Dundalk					Dundalk 21222 13.1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
7433 School Avenue					7433 School Avenue				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last HOMER ANDERSON MOORE					Month Day Year January 31, 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
male		white		WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 9, 1915		51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Foreman				Steel		Baltimore, Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Joel J. Moore					Sarah Hitchcock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
yes					WWII		215-07-2148 Helen Pasek Moore, same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 METASTATIC CARCINOMA DUE TO (b) (PRIMARY UNCERTAIN) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-9, 1966, to 1-31, 1967, that (I) (we) last saw the deceased alive on 1-25, 1967, and that death occurred at 2 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Carlton L. Sexton						22b. DATE SIGNED 2/1/67		22c. PHYSICIAN'S NAME (Type) Carlton L. Sexton, MD.	
22d. ADDRESS 819 Park Avenue, Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			2/3/1967		Druid Ridge Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.						25a. REC'D BY REGISTRAR FEB 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00367

CERTIFICATE OF DEATH

00370

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 5 mths.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armaccost Nursing Home		d. STREET ADDRESS Holly Hill Farm 21030	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle MORGAN Last MORGAN		4. DATE OF DEATH Month January Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Goebel		14. MOTHER'S MAIDEN NAME Marie Hotz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-12-6874	
17. INFORMANT Armaccost Nursing Home		Address Regester Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO A.S.C.V. DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 YRS. (c) 10 YRS.		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 17, 1966 to JAN. 17, 1967 , that (I) (we) last saw the deceased alive on JAN. 17, 1967 , and that death occurred at 9:30 A.M. , from causes on and on the date stated above.			
22a. SIGNATURE Arthur Karfagin		22b. DATE SIGNED 1/18/67	
22c. PHYSICIAN'S NAME (Type) Dr. Arthur Karfagin		22d. ADDRESS 1532 HAVENWOOD RD. Northwood Shopping Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		25a. REC'D BY REGISTRAR DATE JAN 24 1967	
ADDRESS 1050 York Rd.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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OFFICE OF DEATH

00330

Name of Deceased		Date of Death	
Last Name, First Name, Middle Initial		Month, Day, Year	
Age at Death		Sex	
Place of Birth		Cause of Death	
Occupation		Manner of Death	
Residence at Time of Death		Burial Place	
Signature of Informant		Signature of Registrar	
Date of Report		Time of Report	

00368

CERTIFICATE OF DEATH

00371

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			
c. LENGTH OF STAY in lb 7yrs				d. STREET ADDRESS 714 Stevenson Lane			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stella Maris Hospice				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna M. Morris				4. DATE OF DEATH 1/28/67			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/1877	
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Nicholas Cornelius Ganster				14. MOTHER'S MAIDEN NAME Sarah Bullard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 216-09-5443		17. INFORMANT Hospice Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 8, 1959 , 19....., to Jan. 28, 1967 19....., that (I) (we) last saw the deceased alive on 1/26/67 19....., and that death occurred at 5:10P from the causes and on the date stated above.							
22a. SIGNATURE Frank Keuhn M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/28/67	
22c. PHYSICIAN'S NAME (Type) Frank Keuhn, M.D.				22d. ADDRESS Medical Arts Bldg. Baltimore			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/31/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Brooks				ADDRESS Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR DATE FEB 1 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00369					00372				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Green				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Quinque 83.3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7915 St. Monica Drive					d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lizzie Middle E. Last Morris					4. DATE OF DEATH Month January Day 26 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/26/93		9. AGE (in years last birthday) 73 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Morris					14. MOTHER'S MAIDEN NAME Nellie Turner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT (Son-in-law) James M. Woody			Address Maryland 7915 St. Monica Dr. Dundalk,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis DUE TO (c) Diabetes Mellitis								INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr. 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia 3 days								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from November , 19 63 to Jan 25 , 19 67 , that (I) (we) last saw the deceased alive on 1-25- 19 67 , and that death occurred at 6:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Charles E. Thompson M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/26/67		
22c. PHYSICIAN'S NAME (Type) Charles E. Thompson M.D.					22d. ADDRESS 2903 W. Woodwell Rd. Dundalk, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/67		23c. NAME OF CEMETERY OR CREMATORY Ruckersville Cemetery			23d. LOCATION (City, town or county) (State) Ruckersville, Virginia		
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

00332

00332

3 weeks

3 weeks

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None

None

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
00370						00373									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5172 Viaduct Avenue</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u> d. STREET ADDRESS <u>5172 Viaduct Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>S.</u> Last <u>Moszner</u>						4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 25, 1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John L. Kenode</u>						14. MOTHER'S MAIDEN NAME <u>Virginia C.</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Warner Brown 630 Murdock Road</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arteriosclerosis of aorta</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u> <u>5 yrs</u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26, 1967</u> to <u>Jan 27, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>Jan 26, 1967</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>B. B. Brumbaugh M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/27/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>5609 Main St</u>						22d. ADDRESS <u>Elphinstone Rd 41227</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City, town or county) <u>Woodlawn, Md.</u> (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fickens + Sons North Ave.</u>						ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

00370

00370

00370



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00371

CERTIFICATE OF DEATH

00374

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 73 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND JOSEPH MULDOWNEY		4. DATE OF DEATH Month Day Year JANUARY 20 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/98
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Muldowney		14. MOTHER'S MAIDEN NAME Nellie Driscoll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 169-18-0036	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 345X IMMEDIATE CAUSE (a) Cardio Respiratory Failure DUE TO (b) Decubitus Ulcers DUE TO (c) Multiple Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 1/2 Years 3 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 11/8/ , 19 66 , to 1/20/ , 19 67 , that (b) (we) last saw the deceased alive on 1/20/ , 19 67 , and that death occurred at 8:00 PM from causes and on the date stated above.			
22a. SIGNATURE Madhav D. Barhanpurkar		22b. DATE SIGNED 1/21/67	
22c. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/24/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre	23d. LOCATION (City or Town) (County) (State) Philde. Pa.
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons, Inc.		25a. REC'D BY REGISTRAR JAN 25 1967	
25b. REGISTRAR'S SIGNATURE John A. Judge			

00374

RECORD OF DEATH

00374

21 Hours

Death certificate issued

1 Year

Medical license

3 Years

Multiple sclerosis

RECEIVED

1/1/50

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00372 CERTIFICATE OF DEATH 00375

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> 031	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>103 La Paix Lane</u>		d. STREET ADDRESS <u>103 La Paix Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>G</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Hammond</u>	
14. MOTHER'S MAIDEN NAME <u>Myra Grey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. F. W. Bonhage</u> 103 La Paix Lane <u>Towson</u> Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>A-S heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>63</u> to <u>1/6</u> , 19 <u>67</u> that (I) (was) last saw the deceased alive on <u>1/3</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman R. Freeman</u> M.D.		22b. DATE SIGNED <u>1/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN R. FREEMAN JR</u>		22d. ADDRESS <u>11 W 29th St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Md. Balto. Co.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Trickett Som Inc Nt Pa Ave 17</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 9 1967</u>	

08372

0358

251

1. Introduction

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00373

CERTIFICATE OF DEATH

00376

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr6mth27dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle S. Last Murray		4. DATE OF DEATH Month January Day 6 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) steel worker		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. Ohio	11. BIRTHPLACE (County & State, or foreign country) U.S.
13. FATHER'S NAME Clark		14. MOTHER'S MAIDEN NAME Hattie Tyson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-8127	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease with old myocardial infarction DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thrombosis of the vessel of left lower stump			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-8-64 , to Jan. 6, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 6, 1967 , and that death occurred at 8:00 M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 1-6-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-9-1967	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial	23d. LOCATION (City or Town) (County) (State) Belair, Maryland
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222		25a. REC'D BY REGISTRAR DATE JAN 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

00378

CHURCH OF DEATH

00378

1911-12

1912-13

1913-14

1914-15

1915-16

1916-17

1917-18

1918-19

1919-20

1920-21

1921-22

1922-23

1923-24

1924-25

1925-26

1926-27

1927-28

1928-29

1929-30

1930-31

1931-32

1932-33

1933-34

1934-35

1935-36

1936-37

1937-38

1938-39

1939-40

1940-41

1941-42

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00374

CERTIFICATE OF DEATH

00377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>35 TERRACE RD.</u>		d. STREET ADDRESS <u>8041 EDGEWATER</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN A MUTH</u>		4. DATE OF DEATH <u>JAN 29 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 2, 1880</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>29</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>14</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>THOMAS MUTH</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>219-16-5351</u>	
17. INFORMANT <u>ELIZABETH GERBER</u>		Address <u>35 TERRACE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL DECOMPENSATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART</u> DUE TO (c) <u>DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>14 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>APR. 22, 1952</u> , to <u>JAN 29</u> , 1967, that (I) (we) last saw the deceased alive on <u>JAN 28</u> , 1967, and that death occurred at <u>7:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Miceli</u>		22b. DATE SIGNED <u>1/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>		22d. ADDRESS <u>108 S. TAYLOR AVE ESSEX, MD. 21221</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>		25a. REC'D BY REGISTRAR <u>300 MACE</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 31 1967</u>	

00377

0635

00375

CERTIFICATE OF DEATH

00378

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. LENGTH OF STAY IN lb 18 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stringtown Rd.		d. STREET ADDRESS Stringtown Rd.	
3. NAME OF DECEASED (Type or print) John G. Naylor		4. DATE OF DEATH Month January Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1876
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 15 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Balto. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Naylor		14. MOTHER'S MAIDEN NAME Elizabeth E. Bull	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-50-7942	
17. INFORMANT Mrs. Evelyn E. Bull Sparks, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Arterio-sclerosis (c) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis - C.V. Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-10 19 59 to 1-15 19 67 , that (I) (we) last saw the deceased alive on 1-13 19 67 , and that death occurred at 12:00 M., from causes and on the date stated above.			
22a. SIGNATURE M.C. Porterfield		22b. DATE SIGNED 1-17-67	
22c. PHYSICIAN'S NAME (Type) M.C. Porterfield, M.D.		22d. ADDRESS Hampstead, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Upperco, Balto. Co. Md.
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.		25a. REC'D BY REGISTRAR JAN 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2580

87800

00376

CERTIFICATE OF DEATH

Reg. Dist. No. 00379

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				d. STREET ADDRESS 835 Milford Mill Rd. Caton Ridge Nursing Home			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lena Middle Nell Last				4. DATE OF DEATH Month Jan. Day 6 Year 1967			
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mulshefski				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Dr. Arthur Bell 1009 Frederick Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Corruptive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronch Syndrome INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-15, 1964 , to 1-6, 1967 , that I last saw the deceased alive on 1-6, 1967 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Cesar Valle Couero M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Cesar Cavero, M. D. - 8629 Liberty Rd.-Randallstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-67		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR JAN 9 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00370

CERTIFICATE OF DEATH

00370

DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
WITNESSES: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00377

CERTIFICATE OF DEATH

00380

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md. Virginia</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>83. 3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ridgeway Manor Nursing Home</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Josephine C. Nelson</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>4</i> Year <i>19 67</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-28-1886</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Samuel Dix</i>	
14. MOTHER'S MAIDEN NAME <i>Sarah Carman</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Roy L. Nelson 7613 Perring Terrace</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>493X</i> IMMEDIATE CAUSE (a) <i>Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1 week</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>19 Jan</i> , 19 <i>66</i> , to <i>4 Jan</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4 Jan</i> 19 <i>67</i> and that death occurred on <i>6:10 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>William Goodman</i>		22b. DATE SIGNED <i>5 Jan 67</i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM GOODMAN, M.D.</i>		22d. ADDRESS <i>1334 Sutherland Rd - 21229</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>1-9-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Forest Lawn Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Norfolk, Virginia</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 10 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

(M)

00378

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00381

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 222 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA 12-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 243 BODKIN AVENUE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle EARL Last NORATEL		4. DATE OF DEATH Month JANUARY Day 8 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 16, 1900
9. AGE (In years and birthday) 66 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS NORATEL	
14. MOTHER'S MAIDEN NAME ELLA C. DRIVER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1	
16. SOCIAL SECURITY NO. 215 09 1167		17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL DUE TO (b) BRONCHOBENIC CARCINOMA LEFT LUNG WITH METASTASIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MYOCARDIAL INFARCTION, OLD		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from May 31, 1966 , to Jan. 8, 1967 , that (we) last saw the deceased alive on Jan. 8, 1967 , and that death occurred at 11:08 a.m. from causes and on the date stated above.	
22a. SIGNATURE George Dudas, M.D.		22b. DATE SIGNED 19 67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH, Ft. Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. CEMETERY		23d. LOCATION (City or Town) (County) (State) Glen Burnie, A. A. Co., Md.	
24. FUNERAL DIRECTOR George J. Lince		25a. REC'D BY REGISTRAR JAN 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE	

00334

0-8-THREE IN DEATH

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00379

CERTIFICATE OF DEATH

00382

1. PLACE OF DEATH o. COUNTY Baltimore, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 23.1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home				d. STREET ADDRESS 922 Army Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Murdoch Norris				4. DATE OF DEATH Month Day Year January 25th., 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1886		9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Engineer		10b. KIND OF BUSINESS OR INDUSTRY Balto. Aircoil		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward T. Norris				14. MOTHER'S MAIDEN NAME Mary Murdoch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI & WWII		16. SOCIAL SECURITY NO. 212-18-4261A		17. INFORMANT Allan T. Norris		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 63 to 1-25 , 19 67 , that (I) (we) last saw the deceased alive on 1-3-67 , and that death occurred at 2 P.M. from causes and on the date stated above.							
22a. SIGNATURE William G. Helfrich M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich				22d. ADDRESS 5006 Roland Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/1967		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Baltimore, 12, Md.		25a. REC'D BY REGISTRAR DATE JAN 26 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00380

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00383

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> <u>co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>379 HILLEN Rd</u>		d. STREET ADDRESS <u>379 HILLEN Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Henrietta Ora Norris</u>		4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15, 1911</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEM</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years (last birthday) yrs.)
11. BIRTHPLACE (State or foreign country) <u>Harford co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Gray</u>		14. MOTHER'S MAIDEN NAME <u>Ada</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Ralph Norris</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>442X</u> IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clark Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Calma Harford MD</u>
24. FUNERAL DIRECTOR <u>George W TITTLE</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 1967</u>	
ADDRESS <u>Bel Air MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00381

CERTIFICATE OF DEATH

00384

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Nursing Home			d. STREET ADDRESS 3708 Clarenell Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT J. NORWOOD First Middle Last			4. DATE OF DEATH January 10, 1967 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-1889	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William B. Norwood			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME Mary Morrison		
16. SOCIAL SECURITY NO. 714-03-4573			17. INFORMANT Mrs. Ida E. Johnson, 3708 Clarenell Road Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD (c)					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from Feb 9, 1963 to Jan 10, 1967 , that (I) (we) last saw the deceased alive on Jan 9, 1967 , and that death occurred at 11:00 P.M. from causes and on the date stated above.					
22a. SIGNATURE Earl I. Pass		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-11-67	
22c. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass		22d. ADDRESS 4001 Wilkens Avenue, Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-14-1967	23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS			25a. REC'D BY REGISTRAR DATE JAN 12 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

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DEPARTMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
00382					CERTIFICATE OF DEATH					00385				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN lb 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson <i>13.1</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home					d. STREET ADDRESS 806 Scarlett Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) GRACE EDWARDS OLMSTEAD					4. DATE OF DEATH Month Jan. Day 21 Year 19 67									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1884		9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not employed			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Dexter, Iowa			12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Edwin Edwards					14. MOTHER'S MAIDEN NAME Annie Louise Mount									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Merlin Olmstead (son) Same as 2-D									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) GENERALIZED ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH. APP - 1 WK														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from Jan. 11 , 19 60 to JAN 21 , 1967, that (I) (we) last saw the deceased alive on JAN 20 , 1967, and that death occurred at 3:45 M, from causes and on the date stated above.														
22a. SIGNATURE T. C. Siwinski					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/23/67						
22c. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D.					22d. ADDRESS 206 W. Pennsylvania Ave., Towson, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland							
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204					25a. REC'D BY REGISTRAR DATE JAN 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							

00382

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RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00383

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00386

1. PLACE OF DEATH a. COUNTY Balto. (Towson) MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) " "		c. LENGTH OF STAY IN 1b " "	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3037 Northern Pkwy.	
3. NAME OF DECEASED (Type or print) William C. O'Malley		4. DATE OF DEATH Month 1 Day 3 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1897.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditing Dept.		10b. KIND OF BUSINESS OR INDUSTRY B & O R R	9. AGE (In years lost birthday) 69 yrs.
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk. O'Malley		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO. 705-95-2592	
17. INFORMANT Mrs. Maude O'Malley		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		Address (Street, city, town, or county) 1/3/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/6/67.	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00384

00387

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b 2 1/2 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stella Maris Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 106 E. WEST STREET d. STREET ADDRESS 106 E. WEST STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rev. Leo Otterbein First Leo Middle OTTERBEIN				4. DATE OF DEATH Month 1 Day 9 Year 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/81	
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 1 Days 9		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roman Catholic Priest				10b. KIND OF BUSINESS OR INDUSTRY ROMAN CHURCH		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adam Otterbein				14. MOTHER'S MAIDEN NAME Mary Simon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-44-8868		17. INFORMANT Hospice records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) ASCD. (a), stating the underlying cause last. } DUE TO Serious (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 5, 1964 to Jan. 9, 1967 , that (I) (we) last saw the deceased alive on Jan. 9, 1967 , and that death occurred at 2:25 PM from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Mahon				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 204 E Joppa Rd. Towson		22b. DATE SIGNED 1/9/67	
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/13/67		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION (City, town or county) (State) RITCHIE HIGHWAY	
24. FUNERAL DIRECTOR'S SIGNATURE H. W. MEARS & SON				25a. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00385

CERTIFICATE OF DEATH

00388

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr3mth12dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balti more
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 610 Old North Point Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle Gwinn Last Palmer		4. DATE OF DEATH Month January Day 4 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1921
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 45 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hospital attendant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Harrison S. Palmer	
14. MOTHER'S MAIDEN NAME Ethel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Navy	
16. SOCIAL SECURITY NO. 235-28-0827		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Cor pulmonale DUE TO (c) Pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 8:00		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Sept. 22, 1963 , to Jan. 4, 1967 , that he (we) last saw the deceased alive on Jan. 4, 1967 , and that death occurred at 8:00 M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 1-4-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Miller's Cemetery		23d. LOCATION (City or Town) (County) (State) Webster Springs, W. Va.	
24. FUNERAL DIRECTOR Robert Lemmon		25a. REC'D BY REGISTRAR JAN 6 1967	
ADDRESS 4611 Park Heights, Balto. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

4380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00386					00389				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					b. COUNTY Prince George's				
c. LENGTH OF STAY IN Tb 3 months					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital					d. STREET ADDRESS 8138 Balto. Blvd. College Park				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Fred					4. DATE OF DEATH January 29 19 67				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 2-25-87				
9. AGE (In years last birthday) 79 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown					10b. KIND OF BUSINESS OR INDUSTRY unknown				
11. BIRTHPLACE (County & State, or foreign country) Prince George's Co. Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Briton Paragon					14. MOTHER'S MAIDEN NAME Mary ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?					16. SOCIAL SECURITY NO. 520-24-2705A				
17. INFORMANT Records: Spring Grove State Hospital					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebrovascular accident									
DUE TO (b) Arteriosclerosis, generalized and severe									
DUE TO (c) Arteriosclerosis, generalized and severe									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (1) (this hospital) attended the deceased from 10-29-66 , 19 66 to Jan. 29 , 19 67 , that (1) (we) last saw the deceased alive on Jan. 29 , 19 67 , and that death occurred at 12:30 M, from causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar									
22b. DATE SIGNED 2-1-67									
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.									
22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 2/2/67									
23c. NAME OF CEMETERY OR CREMATORY Glen Haven									
23d. LOCATION (City or Town) (County) (State) Ritchie Highway Balto. Md.									
24. FUNERAL DIRECTOR KRAUSE FUNERAL HOME 1216 S. Charles St.									
25a. REC'D BY REGISTRAR FEB 6 1967									
25b. REGISTRAR'S SIGNATURE Charles Judge									

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00387

CERTIFICATE OF DEATH

00390

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Catonsville		c. LENGTH OF STAY IN 1b 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House of Pines-Catonsville, Md.		d. STREET ADDRESS 203 Garden Ridge Rd.	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month Day Year Jan. 29, 1967	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Balt. Transit Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W. I 213-10-0069	
17. INFORMANT Mrs. Mary B. Pascoe		Address 21207 8301 Charmel Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Disorganization 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-5- , 19 64 , to 1-29 , 19 67 , that (I) (we) last saw the deceased alive on 1-28 19 67 , and that death occurred at 2:50 P.M. from causes and on the date stated above			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED 1/31/67	
22c. PHYSICIAN'S NAME (Type) Dr. Wilmer K. Gallagher		22d. ADDRESS 6209 Frederick Rd. 21228 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/1/67	23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Eastern Ave. Balt. Md.
24. FUNERAL DIRECTOR Loring Byers -8728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR FEB 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00388

CERTIFICATE OF DEATH

00392

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 3yrsldy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Portzen Last Portzen				4. DATE OF DEATH Month January Day 5 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-74		9. AGE (In years last birthday) yrs. 92	IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY TOBACCO		11. BIRTHPLACE (County & State, or foreign country) Luxembourg		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicolas Portzen				14. MOTHER'S MAIDEN NAME Margaret Strice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-3276		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Arteriosclerotic cardiovascular heart disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility - Malnutrition							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4-63 , 19 63 to Jan. 5 , 19 67 , that (we) last saw the deceased alive on Jan. 5 , 19 67 and that death occurred at 5:30 M, from causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-5-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-9-67		23c. NAME OF CEMETERY OR CREMATORY ST PETERS CEM.		23d. LOCATION (City or Town) (County) (State) WALDORF, MD.	
24. FUNERAL DIRECTOR South Founal Home, Waldorf, Md				25a. REC'D BY REGISTRAR DATE JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeaway Nursing Home 5743 Edmondson Ave.</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>1426 Burton Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nellie Alice Powers</u>			4. DATE OF DEATH <u>January 10, 1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>May 4, 1871</u>			9. AGE (In years last birthday) <u>95</u> yrs.			10. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Henry Powers</u>			14. MOTHER'S MAIDEN NAME <u>Flora Mackay</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Family Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 782.4 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. b) <u>None</u> c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1966</u> , to <u>Jan 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 6, 1967</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>William Goodman</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>William Goodman</u> 22d. ADDRESS <u>1334 Sulphur Spring Rd - 2122</u> 22b. DATE SIGNED <u>12 Jan 67</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan. 13, 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u>		
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00390			CERTIFICATE OF DEATH				00394		
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup 20794				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 224 Mission Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Matthew Middle Gregory Last PRESTIANNI					4. DATE OF DEATH Month January Day 27 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 27, 1967		9. AGE (In years lost birthday) yrs. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Prestianni					14. MOTHER'S MAIDEN NAME Anna Sullivan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Joseph G. Prestianni, 224 Mission Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrops fetalis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Erythroblastosis fetalis DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (s) (this hospital) attended the deceased from 1/27 , 19 67 , to 1/27 , 19 67 , that (he) (we) last saw the deceased alive on 1/27 , 19 67 , and that death occurred at 1:47 P M, from causes on and on the date stated above.									
22a. SIGNATURE <i>Lawrence J. Misanik</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-27-67		
22c. PHYSICIAN'S NAME (Type) Lawrence J. Misanik					22d. ADDRESS 7620 York Rd, To son, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-28-1967		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cemetery			23d. LOCATION (City or Town) (County) (State) Howard County, Maryland		
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229					25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		c. LENGTH OF STAY IN lb <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8019 Philadelphia Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph A. Priller</u>		4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paint Tinter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brungr Paint Co.</u>	9. AGE (In years (last birthday) yrs.) <u>48</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clement Priller</u>		14. MOTHER'S MAIDEN NAME <u>Katherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>213 01 1452</u>	
17. INFORMANT <u>Dorothy V. Priller</u>		Address <u>1225 Spring Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>1/28</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>1/28</u> , 19 <u>67</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
21a. SIGNATURE <u>John G. Orth, M.D.</u>		21b. DATE SIGNED <u>1-28-67</u>	
22a. PHYSICIAN'S NAME (Type) <u>John G. Orth M.D.</u>		22b. ADDRESS <u>8019 Philadelphia Road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Thos F. Groch</u>		25a. RECEIVED BY REGISTRAR DATE <u>JAN 31 1967</u>	
ADDRESS <u>1211 Chesaco Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00392

CERTIFICATE OF DEATH

00396

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS This is her usual residence 7620 York Road-21204	
3. NAME OF DECEASED (Type or print) Sister M. Agnes Angela OSF(Proctor)		4. DATE OF DEATH January 18th 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-07
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months 03 Days 1 Hours 1 Min. 03-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Proctor		14. MOTHER'S MAIDEN NAME Bridget Lagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister Pierre,		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Right breast with extensive metastasis to ribs.			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 25th 1966 to Jan. 18th 1967 , that (I) (we) last saw the deceased alive on Jan. 18th 1967 , and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Ernesto A. Hipolito		22b. DATE SIGNED Jan. 18th 1967	
22c. PHYSICIAN'S NAME (Type) Ernesto A. Hipolito MD		22d. ADDRESS 7620 York Road, Towson 21204, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/67.	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR JAN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

00397

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2522 LIBERTY PARKWAY		d. STREET ADDRESS 2522 LIBERTY PKWY	
3. NAME OF DECEASED (Type or print) First Middle Last J. HARRY PROWELL		4. DATE OF DEATH Month Day Year JAN 8 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 18 1887
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ORDER CLERK		9b. KIND OF BUSINESS OR INDUSTRY STEEL	9c. BIRTHPLACE (County & State, or foreign country) PENNA
10. FATHER'S NAME WILLIAM R. PROWELL		11. MOTHER'S MAIDEN NAME JENNIE ELCOCK	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		13. SOCIAL SECURITY NO. MRS RUTH PROWELL 2522 LIBERTY PKWY	
14. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Lung C 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) Metastasis (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		15. INTERVAL BETWEEN ONSET AND DEATH	
16a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		16b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
17a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	17b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	17c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	17d. (City or town) (County) (State)
18. I certify that (I) (this hospital) attended the deceased from Dec 1 1966 to Jan 8 1967 , that (I) (we) last saw the deceased alive on Jan 7 1967 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
19a. SIGNATURE M. B. DAVIS		19b. DATE SIGNED 1/9/67	
19c. PHYSICIAN'S NAME (Type) M. B. DAVIS M.D.		19d. ADDRESS 6800 MORNINGTON ROAD	
20a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	20b. DATE THEREOF 1/11/67	20c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	20d. LOCATION (City, town or county) (State) BROOKLYN MD
21. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME - DUNDALK MD		22. ADDRESS ULLRICH FUNERAL HOME - DUNDALK MD	
23a. REC'D BY REGISTRAR JAN 12 1967		23b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00394					00391				
1. PLACE OF DEATH a. COUNTY <u>Baltimore,</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2803 Garrison Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE H. PURNELL (PERNELL)			4. DATE OF DEATH Month Day Year Jan. 6 1967		9. AGE (In years) (If UNDER 1 YEAR IF UNDER 24 HRS. Yrs. Months Days Hours Min.) 72 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-4-94		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Med. Record			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>148X</u> RESPIRATORY OBSTRUCTION DUE TO Carcinoma of Pharynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH immediate ?Duration	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>67</u> , to <u>1-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>David F. Fairbanks</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6 JAN 67</u>			
22c. PHYSICIAN'S NAME (Type) DAVID F. FAIRBANKS				22d. ADDRESS 6BMC No. Charles, Baltimore					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem		23d. LOCATION (City, town or county) (State) Anne Arundel Cty. Md.			
24. FUNERAL DIRECTOR Wm. C. March 928 E. North Ave				25a. REC'D BY REGISTRAR DATE JAN 10 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00395

CERTIFICATE OF DEATH

00398

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 2527 Taylor Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Hans A. W. Quade		4. DATE OF DEATH Month Day Year January 8 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1900
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Jeweler		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Quade		14. MOTHER'S MAIDEN NAME Helen Kleist	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214011675	
17. INFORMANT Anna Quade		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis of left upper lobe. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rectum.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 6, 19 67 , to January 8, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 8, 19 67 , and that death occurred at 5:35 PM from causes and on the date stated above.			
22a. SIGNATURE M.S. Cockburn M.D.		22b. DATE SIGNED January 9, 1967	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1-11-67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		25a. REC'D BY REGISTRAR DATE JAN 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

00396

00399

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>			d. STREET ADDRESS <u>7407 Kalton Court #8</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Albert I. Rankin</u>			4. DATE OF DEATH <u>January 16, 1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1897</u>		9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Lasting Products</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Mendel Rankin</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>216-09-7570</u>		17. INFORMANT <u>Mr. Martin Rankin, 7429 Kalton Court #8</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Progressive cerebral degeneration</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>67</u> , to <u>16 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 Jan</u> 19 <u>67</u> , and that death occurred at <u>2 P.</u> M, from causes and on the date stated above					
22a. SIGNATURE <u>William Goodman</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>17 Jan 67</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. William Goodman</u>			22d. ADDRESS <u>1345 Sulphur Springs Road</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moses Montifiore</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>			25a. REC'D BY REGISTRAR <u>JAN 23 1967</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00330

CERTIFICATE OF DEATH

00330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
00397					CERTIFICATE OF DEATH					00400																			
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge Route 4					d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridgeway Manor Nursing Home																			
3. NAME OF DECEASED (Type or print) First BESSIE Middle D. Last RAY					4. DATE OF DEATH Month Jan. Day 14 Year 1967					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1880		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 13 Days 2		IF UNDER 24 HRS. Hours 13 Min. 2																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY?														
13. FATHER'S NAME Arthur Chenoweth					14. MOTHER'S MAIDEN NAME Sarah Swartz					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Joseph H. Ray, Monrovia, Md					Address 21770				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 day																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 9 Jan , 19 67 , to 14 Jan , 19 67 that (I) (we) last saw the deceased alive on 13 Jan , 19 67 , and that death occurred at 12:55 PM , from the causes and on the date stated above.										22a. SIGNATURE William Goodman, M.D.					22b. DATE SIGNED 16 Jan 67														
22c. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, M.D.					22d. ADDRESS 1334 S. ...																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-17-1967					23c. NAME OF CEMETERY OR CREMATORY Prospect Hill					23d. LOCATION (City, town or county) (State) Towson, Md														
24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md					25a. REC'D BY REGISTRAR JAN 18 1967					25b. REGISTRAR'S SIGNATURE Charles Judge																			

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00398

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore c. LENGTH OF STAY IN lb 8½ years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Augsburg Lutheran Home 6811 Campfield Road 21207		d. STREET ADDRESS 3820 Parkmont Avenue	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Richard		4. DATE OF DEATH January 7 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/88
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bloberger		14. MOTHER'S MAIDEN NAME Meta Margaret Pestrup	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-34-1635A	
17. INFORMANT Paul A. Hauer		Address 6811 Campfield Road 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with Fibrillation DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19 to Jan-7 , 19 67 , that (I) (was) saw the deceased alive on Jan. 5 , 19 67 , and that death occurred at 50 M, from causes and on the date stated above.			
22a. SIGNATURE Earl L. Chambers		22b. DATE SIGNED 1/7/67	
22c. PHYSICIAN'S NAME (Type) Earl L. Chambers		22d. ADDRESS 4108 Liberty St. Balto. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1/10/67	23c. NAME OF CEMETERY OR CREMATORY Grady Paul	23d. LOCATION (City or Town) (County) (State) Balto Md
24. FUNERAL DIRECTOR W. Deemann		25a. REC'D BY REGISTRAR JA: 11 1967	
25b. PHOTOGRAPH SIGNATURE W. Deemann		25c. PHOTOGRAPH SIGNATURE W. Deemann	

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00399

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00402

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Rural			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Rural 13.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 Fleming Drive				d. STREET ADDRESS 200 Fleming Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RONALD Middle KEITH Last RICHARDSON				4. DATE OF DEATH Month January Day 23 Year 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1966		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Ramsome				14. MOTHER'S MAIDEN NAME Theresa Richardson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Leon Richardson 200 Fleming Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Interstitial Pneumonitis. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 1/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City or Town) (County) (State) A.A. Co., Md.	
24. FUNERAL DIRECTOR ADDRESS Morton & Dyett F.H. 1701 Laurens str.				25a. REC'D BY REGISTRAR JAN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00400

CERTIFICATE OF DEATH

00403

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 34 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing & Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY HERSHEY RIDDLE		4. DATE OF DEATH Month Day Year Jan. 3, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Employed by Builders	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Edwin Riddle		14. MOTHER'S MAIDEN NAME Mary Erene Hershey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-8838 A	
17. INFORMANT Mrs. Thomas Lawrence		Address 21228 218 EXXX Newburg Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) stroke			INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 25, 1961 , to Jan 3, 1967 , that (I) (we) last saw the deceased alive on Jan 2, 1967 , and that death occurred at 6:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Nesbitt Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-4-67
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt Jr. M.D.		22d. ADDRESS 1009 Frederick Rd. Catonsville, 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/5/1967	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City or Town) (County) (State) Ellicott City Howard Co., Md.
24. FUNERAL DIRECTOR Easton Funeral Home		ADDRESS Catonsville, Md.	25a. REC'D BY REGISTRAR DATE JAN 5 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF ADEQUACY

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Name of the person or organization		Address		City	
State		County		Zip	
Description of the project or activity					
Purpose of the project or activity					
Estimated cost of the project or activity					
Estimated value of the project or activity					
Estimated number of people involved					
Estimated number of hours involved					
Estimated number of days involved					
Estimated number of weeks involved					
Estimated number of months involved					
Estimated number of years involved					
Estimated number of people involved					
Estimated number of hours involved					
Estimated number of days involved					
Estimated number of weeks involved					
Estimated number of months involved					
Estimated number of years involved					

00401

CERTIFICATE OF DEATH

00404

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE MARSH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE MARSH</u> <u>13.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RTE 1 BOX 118 VINCENT RD</u>		d. STREET ADDRESS <u>RTE 1 BOX 118 VINCENT RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA</u> <u>NORA</u> <u>RIFFLE</u>		4. DATE OF DEATH Month Day Year <u>JAN</u> <u>19</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 2 1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CONRAD</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LOUIE FOLEY ABOVE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident Immediate</u> <u>443X</u> DUE TO (b) <u>Hypertensive arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>vascular disease</u> DUE TO <u>+</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> , to <u>Jan 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1967</u> , and that death occurred at <u>1:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>1-20-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/23/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00402 CERTIFICATE OF DEATH 00405											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>56 Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10708 Tyne Ave</u> d. STREET ADDRESS <u>10708 Tyne Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORRIS ROBERT RILEY</u>						4. DATE OF DEATH Month Day Year <u>Jan. 4 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-92</u>		9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinetmaker-Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOSHUA RILEY</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET LEESE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WWI WWI</u>						16. SOCIAL SECURITY NO. <u>212-01-1547</u>			17. INFORMANT <u>Wife</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO (b) <u>Artero-sclerotic vasculon</u> DUE TO (c) <u>disease.</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>67</u> , to <u>Jan 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 4</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>M. I. MacGregor</u>						22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <u>1. Mac GREGOR.</u>						22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN. 7, 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>POPLAR GROVE CEM.</u>			23d. LOCATION (City, town or county) (State) <u>COCKEYSVILLE, MD.</u>		
24. FUNERAL DIRECTOR <u>John Sammons</u>						25a. REC'D BY REGISTRAR <u>John Sammons</u>					
25b. REGISTRAR'S SIGNATURE <u>John Sammons</u>						25c. DATE <u>JAN 9 1967</u>					

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WILLIAM H. HARRIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00403 CERTIFICATE OF DEATH					00406				
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK MD.</u> c. LENGTH OF STAY IN 1b <u>11 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO. MED. CENTER</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> <u>21222 031</u> d. STREET ADDRESS <u>2954 Sollers Pl. Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>JACOB</u> First <u>RAYMOND</u> Middle <u>RITZMAN</u> Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			4. DATE OF DEATH <u>JAN.</u> Month <u>5</u> Day <u>1967</u> Year			8. DATE OF BIRTH <u>11/27/15</u> 9. AGE (In years last birthday) <u>51</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSTALLING STORM WINDOWS</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>SHAMONKIN, PENNA.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JACOB M RITZMAN</u> 14. MOTHER'S MAIDEN NAME <u>CARRIE ROSS</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 16. SOCIAL SECURITY NO. <u>42-45-210-16400</u> 17. INFORMANT <u>PATIENT'S CHART</u> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PERITONITIS</u> <u>140-18-8287</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>PERFORATED PEPTIC ULCER, STOMACH</u> DUE TO (c) <u>570.1</u>								INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF LUNG WITH METASTASES</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-5-67</u> , 19 <u>67</u> , to <u>1-5-67</u> , 19 <u>67</u> , that (I) <u>two</u> last saw the deceased alive on <u>1-5-67</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>R. Chiller</u>					22b. DATE SIGNED <u>1-5-67</u>			22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHILLAR</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1/9/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>C.O.D. FELLOWS</u>		23d. LOCATION (City, town or county) (State) <u>SHAMONKIN PENNA</u>		
24. FUNERAL DIRECTOR <u>Arthur Bradley, Dundalk, MD</u>					25a. REC'D BY REGISTRAR <u>JAN 9 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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RAM K. CHILKOTI

[Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00404

CERTIFICATE OF DEATH

00407

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u> <u>16-2</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE ST. HOSPITAL</u>		d. STREET ADDRESS <u>9005 48TH PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>(H) HELEN</u> First <u>M</u> Middle <u>ROBERTS</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-98</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>HOWARD MARSHALL</u>		14. MOTHER'S MAIDEN NAME <u>ESTELLA CURTIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-54-9826</u>	17. INFORMANT Address <u>HOSPITAL RECORDS</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>67</u> to <u>1-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-13</u> 19 <u>67</u> , and that death occurred at <u>7:22</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando Vieta</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>1-13-67</u>
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO VIETA</u>		22d. ADDRESS <u>SPRING GROVE ST. HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 17, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Ft Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor</u> <u>Pro Geo</u> <u>Md.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	25a. REC'D BY REGISTRAR DATE <u>JAN 16 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00407

RECORD OF DEEDS

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00405

CERTIFICATE OF DEATH

00408

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN lb 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 452 Main Street		d. STREET ADDRESS 452 Main Street	
3. NAME OF DECEASED (Type or print) First Max Middle L. Last Robertson		4. DATE OF DEATH Month January Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1885
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Builder		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Robertson		14. MOTHER'S MAIDEN NAME James A. Shelton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-1197	
17. INFORMANT Mrs. Martha E. Robertson		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Myocarditis - Chronic DUE TO decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular system DUE TO (arteriosclerosis) disease (c) arthritis			INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 1-10-67 , that (I) (we) lost saw the deceased alive on 1-1-1967 , and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 1-11-67	
22c. PHYSICIAN'S NAME (Type) James G. Saffell MD		22d. ADDRESS Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/13, 67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Pikesville, Md.
24. FUNERAL DIRECTOR J. F. Eline & Sons		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE J. F. Eline & Sons		25c. DATE JAN 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

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08403

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00406

CERTIFICATE OF DEATH

00409

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>		d. STREET ADDRESS <u>5027 57th Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cecelia</u> Middle <u>Anne</u> Last <u>Roeder</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1962</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lindwood T Roeder</u>		14. MOTHER'S MAIDEN NAME <u>Esther M. Price</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records - Rosewood State Hosp. - Owings Mills</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>045.4</u> IMMEDIATE CAUSE (a) <u>Shigelosis with hemorrhagic diarrhea</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Institutionalized due to Mongoloid status. 1 week</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12-21</u> , 19 <u>66</u> to <u>1-2</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>1-2</u> , 19 <u>67</u> , and that death occurred at <u>1:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Jones</u> M.D.		22b. DATE SIGNED <u>3 Jan '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard A. Jones</u>		22d. ADDRESS <u>Carroll County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

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Richard A. Jones

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Yatesville, Va.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO. CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHANGRI-LA HOME</u>		d. STREET ADDRESS <u>701 DORCHESTER RD.</u>	
3. NAME OF DECEASED (Type or print) <u>FLORA B. ROGERS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/72</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>EDW. WALKER</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHY HAWKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>WILMA NOTT</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>22</u> <u>20 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> , 19 <u>65</u> , to <u>1/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>67</u> , and that death occurred at <u>1P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>James E. Rowe</u>		22b. DATE SIGNED <u>1/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. ROWE</u>		22d. ADDRESS <u>CATONSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH</u>	23d. LOCATION (City or Town) (County) (State) <u>HOWARD CO. MD.</u>
24. FUNERAL DIRECTOR <u>E.S. MALNABB</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>	
301 FREDERICK RD <u>21228</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00410

CERTIFICATE OF DEATH

00410

Blank certificate form with faint horizontal lines and a large, faint circular stamp in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00408

CERTIFICATE OF DEATH

00411

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> <u>13.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8722 Church Lane</u>				d. STREET ADDRESS <u>8722 Church Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE (KATE) ROGERS</u>				4. DATE OF DEATH Month Day Year <u>JAN. 16 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 8, 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM GHENT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HARDEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>LILLIAN DORSEY</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerotic Heart Failure</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/12, 1957</u> to <u>1/16, 1967</u> , that (I) (we) lost saw the deceased alive on <u>1/15, 1967</u> , and that death occurred at <u>10:30 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edwin L. Pierpont</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD. - BALTO., MD. 21207</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST THOMAS</u>		23d. LOCATION (City or Town) (County) (State) <u>RANDALLSTOWN MD</u>	
24. FUNERAL DIRECTOR <u>WILLIAM MARCH 928 E. NORTH AVE</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

11200

UNITED STATES DEPARTMENT OF AGRICULTURE

00100

UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

00409

CERTIFICATE OF DEATH

00412

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>6 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md.</u> <u>Chapel Hill Nursing Home, Randallstown</u>				d. STREET ADDRESS <u>10 Cliveden Road</u>		13-1	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander Romans</u>				4. DATE OF DEATH Month Day Year <u>January 30 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1881</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor-self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM Romans</u>				14. MOTHER'S MAIDEN NAME <u>BETTIE SCOTT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Mr. Harry H. Meeks, P.O. Box 87, Glen Burnie, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Lobar</u> 443X DUE TO <u>Myocarditis - decompensating</u> (b) <u>Hyperextension - General</u> DUE TO <u>arteriosclerotic disease</u> (c) <u>arteriosclerotic disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>month</u> <u>year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>✓</u> 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. (City or town) (County) (State) <u>✓</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12-10</u> , 19 <u>66</u> to <u>1-30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1-30</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James G. Saffell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell M.D.</u>				22d. ADDRESS <u>Reisterstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville 8, Md</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51280

0-9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ZDM 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00410					00413				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pikesville			b. COUNTY				
c. LENGTH OF STAY IN					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Professional House, Inc.			d. STREET ADDRESS		3813 Menlo Drive		
3. NAME OF DECEASED (Type or print)		Miriam - Rosenfeld			4. DATE OF DEATH		1 10 1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 95 yrs.	
F		W				9/1/71			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None		None		Baltimore, Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Michael Rosenfeld		Carolyn Weisenfeld		No		220-44-8362		Mr. Irvin E. Robinson, 3813 Menlo Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio sclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 10-2, 1965, to 1-10, 1967, that (I) (we) last saw the deceased alive on 1-10-1967, and that death occurred at 7:40 PM, from the causes and on the date stated above.									
22a. SIGNATURE David L. Miller M.D.									
22b. DATE SIGNED 1-10-67									
22c. PHYSICIAN'S NAME (Type) David F. Miller									
22d. ADDRESS 11000 Rd. Owings Mills, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 1/13/67									
23c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew									
23d. LOCATION (City, town or county) (State) Baltimore, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sol Levinson & Bros. Inc., 6010 Reist., Rd.									
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge									
DATE JAN 16 1967									

00113

00113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
00411		CERTIFICATE OF DEATH		00414	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 43 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 1901 16th Street, NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOUISE Middle VIRGINIA Last ROSS			4. DATE OF DEATH Month JANUARY Day 11 Year 67		
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 30, 1919	9. AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (County & State, or foreign country) LEXINGTON, VIRGINIA	
13. FATHER'S NAME NAME UNKNOWN			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PL 28		16. SOCIAL SECURITY NO. 227 14 23 02		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF ANEURYSM OF LEFT VENTRICLE, ACUTE DUE TO (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC CORONARY THROMBOSIS					INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/29/66 , 19__ to 1/11/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/11/67 , 19__, and that death occurred at 11:50PM on causes and on the date stated above.					
22a. SIGNATURE <i>George Dudas</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/12/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/16/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR <i>Irvin P. Carroll</i>		IRVIN P. CARROLL FUNERAL HOME 1712 W. North Ave. Baltimore, Md.		25a. REC'D BY REGISTRAR JAN 16 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>	

00418

00418

DEPARTMENT OF COMMERCE

DEPARTMENT OF COMMERCE

WASHINGTON

13 MAY 1917

FORT HOWARD

1201 15th Street, NW

WASHINGTON, D.C.

JANUARY 12

ROSS

VIRGINIA

INDIAN

AUGUST 30, 1917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00412						00415							
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Rural)</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30.4</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>						d. STREET ADDRESS <u>B 628 E 14 Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Elsie</u>			First <u>Bertha</u> Middle <u>Rene</u> Last			4. DATE OF DEATH <u>1</u> <u>25</u> <u>1967</u>			Month <u>1</u> Day <u>25</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-17-08</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>William Edward Wood</u>						14. MOTHER'S MAIDEN NAME <u>? Bussey</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>913-28-8614</u>		17. INFORMANT <u>PATIENT'S</u> Address <u>CHART</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 Carcinoma of Ampulla of Vater</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Edmund De Marchena</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>1/25/67</u>				
22c. PHYSICIAN'S NAME (Type) _____						22d. ADDRESS <u>G.B.M.C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						ADDRESS _____			25a. REC'D BY REGISTRAR <u>J Charles Judge</u> 25b. REGISTRAR'S SIGNATURE				
DATE <u>JAN 26 1967</u>													

00412

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Committee of Officials of Veterans
Congressional Committee
Congressional Committee

Committee of Officials

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Committee of Officials

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

00413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00416

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 236 Second Avenue		d. STREET ADDRESS 236 Second Avenue	
3. NAME OF DECEASED (Type or print) ELMER C. RUSSELL SR.		4. DATE OF DEATH January 25, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor		10b. KIND OF BUSINESS OR INDUSTRY B & O RR	9. AGE (In years last birthday) yrs. 72
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Russell		14. MOTHER'S MAIDEN NAME Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Blanche C. Russell, 236 Second Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 422.1 Arteriosclerotic Cardiovascular Disease - Sudden IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pt. known to have had Cirrhosis 2-1963			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James N. Frederick Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) J.N. Frederick		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-28-1967	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Howard County, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JAN 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 1/24/67	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00414 CERTIFICATE OF DEATH 00417											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12 03.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 506 Overbrook Rd.						d. STREET ADDRESS 506 Overbrook Rd.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Vasiliky Sakelos						4. DATE OF DEATH Month Day Year 1 22 19 67					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-1891		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Greece				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Constantine Hanges						14. MOTHER'S MAIDEN NAME Georgia Papacoultsoula					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO. 213-34-4532		17. INFORMANT Mrs. Peter Calvert Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Atherosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 hrs 4+30	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 25, 1963 to Jan 22, 1967 , that (I) (we) last saw the deceased alive on Dec 27, 1966 , and that death occurred at 8:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Fredrick J. Vollmer						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-23-67			
22c. PHYSICIAN'S NAME (Type) F. Vollmer						22d. ADDRESS 6100 York Rd., Balto. 12, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 1-25-67		23c. NAME OF CEMETERY OR CREMATORY Woodlawn				23d. LOCATION (City, town or county) (State) Woodlawn Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						ADDRESS 4905 York Rd., Balto.		25a. REC'D BY REGISTRAR JAN 23 1967			
								25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

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CERTIFICATE OF DEATH

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
00415					CERTIFICATE OF DEATH					00418				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				0.3.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital					d. STREET ADDRESS 6905 Windsor Mill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Robert Mitchell SAWYER					4. DATE OF DEATH Month Day Year January 22, 19 67									
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-41		9. AGE (In years last birthday) yrs. 25		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Renzy Mitchell Sawyer					14. MOTHER'S MAIDEN NAME Stella Frances Phelps									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolite Imbalance 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Empiema Left Chest. DUE TO (c) hephtosis - Strongyloidiasis								INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mongolism								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 2-27, 1962 to 1-22, 1967 , that (I) (we) last saw the deceased alive on 1-22, 1967 , and that death occurred at 8:30 AM , from causes and on the date stated above.														
22a. SIGNATURE Esteban V. Diaz					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) ESTEBAN V. DIAZ					22d. ADDRESS 321-E. BELCREST - BELAIR-MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/24/67		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or town) (County) (State) Woodlawn, Md.								
24. FUNERAL DIRECTOR Wm. J. Dickner & Sons					ADDRESS North & Lenox		25a. REC'D BY REGISTRAR DATE JAN 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones					

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CERTIFICATE OF DEATH

00416

00419

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21214 20.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1806 Heathfield Road	
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last SCHOBER		4. DATE OF DEATH Month January Day 11 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-83
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kraus		14. MOTHER'S MAIDEN NAME Wilhemina Brauch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 2I6 07 2262	
17. INFORMANT Mrs. C. Loretta Link		Address 1806 Heathfield Balto.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial Ischemia - Coronary arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arterial Embolism DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholecystectomy - Exploration of Common Bile Duct			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from Dec. 30th, 1966 to Jan. 11 1967 , that (I) (we) last saw the deceased alive on Jan. 11 1967 , and that death occurred at 4:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE Roberto Ferrer		22b. DATE SIGNED Jan. 11 1967	
22c. PHYSICIAN'S NAME (Type) Roberto O. Ferrer M.D.		22d. ADDRESS 7620 York Road, Towson 21204, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25. REC'D BY REGISTRAR DATE JAN 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00417

00420

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph's Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6207 Marglen Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Rose Middle Schonhoff Last 			4. DATE OF DEATH Month Jan. Day 30 Year 19 67		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-80 82		9. AGE 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Alexander McCoy		14. MOTHER'S MAIDEN NAME Katherine Goob			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 220-54-7277		17. INFORMANT Address Mrs. Mary C. Thomas - 6207 Marglenn Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PUL MONARY EMBOLISM 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) FRACTURE, LEFT HIP					INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) FELL OUT OF BED AT HOME			
20c. TIME OF INJURY Month, Day, Year JAN 10 19 67 Hour 8 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	
20f. (City or town) BALTIMORE		20g. (County) MD		20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/31/67	
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Baltimore, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-67		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
22d. LOCATION (City, town, or country) Baltimore, Maryland		(State)			
23. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		ADDRESS		24a. REC'D BY REGISTRAR FEB 7 1967	
				24b. REGISTRAR'S SIGNATURE J Charles Judge	

VR A15ME
5M 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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00418

CERTIFICATE OF DEATH

00421

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>30.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>2807 HOLLINS FERRY</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>G.</u> Last <u>SCHULER</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>73</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Schuler</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Achler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>26-Aug-18-</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Ada Schuler - same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Bronchopneumonia, R & L lobes, heavy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Acute Renal Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-67</u> , 19 <u>67</u> , to <u>1/19/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-19-67</u> , 19 <u>67</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Evangelina Ramos/MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EVANGELINA RAMOS</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>24 Jan 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3300

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00422

00419

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>13.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6103 TALLES ROAD</u>		d. STREET ADDRESS <u>6103 TALLES ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIAN SCHWARTZMAN</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 22, 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BORIS ALPER</u>		14. MOTHER'S MAIDEN NAME <u>ETTA ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MR. BORIS SCHWARTZMAN</u>		Address <u>5125 NELSON AVENUE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depressive Reaction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>1-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April</u> 19 <u>66</u> , and that death occurred at <u>1P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Stanley R Steinbach</u>		22b. DATE SIGNED <u>1-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. STANLEY R. STEINBACH</u>		22d. ADDRESS <u>11 SLADE AVENUE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANSHE EMUNAH</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u>		25. REC'D BY REGISTRAR DATE <u>JAN 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00420					CERTIFICATE OF DEATH			00423	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 10mth27dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 3024 Fifth Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Natalie Serovy					4. DATE OF DEATH Month Day Year January 10 19 67				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1910		9. AGE (In years last birthday) yrs. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Azymanski					14. MOTHER'S MAIDEN NAME Vearlie Londell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 176-09-8175		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pick's Disease								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (#) (this hospital) attended the deceased from Feb. 7, 1966 to Jan. 10, 1967 , that (#) (we) last saw the deceased alive on Jan. 10, 1967 , and that death occurred at 12:45 M. from causes and on the date stated above.									
22a. SIGNATURE Anthony J. Young, M.D.					22b. DATE SIGNED 1-10-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/11/66		23c. NAME OF CEMETERY OR CREMATORY ST. MARK MEM. PK.		23d. LOCATION (City or Town) (County) (State) LOWER BURRELL, PA.			
24. FUNERAL DIRECTOR E.S. MACNABB					25a. REC'D BY REGISTRAR DATE JAN 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
00421		CERTIFICATE OF DEATH		00424	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		d. STREET ADDRESS 405 Swann Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE M. SESSIONS		4. DATE OF DEATH Month January Day 29 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6-24- 1888	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Henry Hellmann		14. MOTHER'S MAIDEN NAME Caroline Blaney		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Mary Louise Sessions, 405 Swann Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Carcinoma Colon DUE TO Pulmonary Emphysema (b) Pulmonary Hypertension DUE TO Pulmonary Hypertension (c) Pulmonary Hypertension		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 to Jan 29, 1967 , that (I) (we) last saw the deceased alive on Jan 28, 1967 , and that death occurred at 2:15 PM , from causes and on the date stated above.					
22a. SIGNATURE John C. Healy		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/30/67	
22c. PHYSICIAN'S NAME (Type) Dr. John C. Healy		22d. ADDRESS 1311 Francis Avenue, Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2- 1-1967		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland					
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00422

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00425

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Virginia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNANDALE</u> d. STREET ADDRESS <u>6922 Terrace Pl.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Warner Cornelious Settle</u>		4. DATE OF DEATH <u>JAN. 5 1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/4/21</u>		9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MGX</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>ANNANDALE Gulf</u>				11. BIRTHPLACE (County & State, or foreign country) <u>WARSAW, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Warner Settle</u>						14. MOTHER'S MAIDEN NAME <u>Brook</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>212-30-1230</u>				17. INFORMANT <u>Patient's Chart</u>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>603X ACUTE RENAL FAILURE</u> DUE TO (b) <u>ACUTE CORTICAL NECROSIS OF KIDNEYS</u> DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PERITONITIS FROM PERFORATED PEPTIC ULCER</u>																			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29th, 1966</u> , to <u>Jan. 5th, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5th, 1967</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>M. I. MacGregor</u>												22b. DATE SIGNED <u>Jan. 5th, 1967</u>							
22c. PHYSICIAN'S NAME (Type) <u>M. I. MAC GREGOR</u>												22d. ADDRESS <u>Gr. Baltimore Medical Centre</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/9/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Arlington VA.</u>							
24. FUNERAL DIRECTOR <u>RJ. Murphy</u>												25a. REC'D BY REGISTRAR <u>JAN 11 1967</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

00332

00332



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00423					00426									
Item 8 Film 0385 2/6/67 mb														
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b. 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Balto. Medical Center					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN d. STREET ADDRESS 3411 CARROLL AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First EDMUND Middle Last SHAW JR.					4. DATE OF DEATH Month JANUARY Day 25 Year 1967									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/1896		9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETD. FURNITURE SALESMAN			10b. KIND OF BUSINESS OR INDUSTRY FURNITURE			11. BIRTHPLACE (County & State, or foreign country) BALTO. PA.		12. CITIZEN OF WHAT COUNTRY? USA.						
13. FATHER'S NAME EDMUND SHAW SR.					14. MOTHER'S MAIDEN NAME LYDIA MYERS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) NAVY WWI					16. SOCIAL SECURITY NO. 213-10-5760					17. INFORMANT Miss Katherine Q. Shaw Address 3411 Carroll Ave Randallstown				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO (b) CEREBRAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH ONE WEEK														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12-28- , 1966, to 1-25- , 1967, that (I) (we) last saw the deceased alive on 1-25- , 1967, and that death occurred at 12:30 PM , from the causes and on the date stated above.														
22a. SIGNATURE E. K. S. Narayanan					22b. DATE SIGNED 1-25-1967									
22c. PHYSICIAN'S NAME (Type) EDATHIL K. S. NARAYANAN					22d. ADDRESS GREATER BALTIMORE MEDICAL CENTER TOWSON, MARYLAND 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan 28/67		23c. NAME OF CEMETERY OR CREMATORY Edwin Ridge Cemetery			23d. LOCATION (City, town or county) (State) Pikesville Md.							
24. FUNERAL DIRECTOR Loring Byers ADDRESS 8728 Liberty Road					25a. REC'D BY REGISTRAR JAN 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							

00433

00433

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

2. The second part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

3. The third part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

4. The fourth part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

5. The fifth part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

6. The sixth part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

7. The seventh part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

8. The eighth part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

9. The ninth part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

10. The tenth part of the report is a statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00424					00427				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore TOWSON</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore COCKEYSVILLE 03.1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>					d. STREET ADDRESS <u>3 Hillside AVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur William Shock</u>		4. DATE OF DEATH Month Day Year <u>1 23 1967</u>							
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-1896</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oilier - RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>H.T. CAMPBELL CORP.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George H. Shock</u>			14. MOTHER'S MAIDEN NAME <u>DARKS REBECCA PARKS</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-07-2001</u>		17. INFORMANT <u>FAMILY RECORDS</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> (c) <u>Carcinoma of bladder</u> DUE TO DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27, 1966</u> , to <u>Jan. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1967</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert W. Smith</u>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 23, 1967</u>				
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SATER'S CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>LUTHERVILLE, MARYLAND</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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00424

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Uremia
Concussion of Hobbs

Jan. 22, 01

Robert W. Knight

X

Jan. 22, 01

Jan. 22, 01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

00425

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00428

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 339 Fifth Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Berlie Middle M. Last Shrieves		4. DATE OF DEATH Month January Day 13 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1903
9. AGE (In years) 63 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Shrieves		14. MOTHER'S MAIDEN NAME Emma Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-4735	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized and cerebral arteriosclerosis - Chronic alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Jan. 10, 1967 to Jan. 13, 1967 , that he (we) last saw the deceased alive on Jan. 13, 1967 , and that death occurred at 1:20 M, from causes on and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 1-13-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE JAN 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

00500

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00426					00429				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 7 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 75 Del Rio Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 75 Del Rio Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Harry Middle M. Last Siegle			4. DATE OF DEATH Month January Day 9 Year 19 67						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/7/96		9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months 0 Days 3 IF UNDER 24 HRS.: Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Foreman, Retired			10b. KIND OF BUSINESS OR INDUSTRY M. A. Long		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Christian Siegle					14. MOTHER'S MAIDEN NAME Henrietta Schaffer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 216-05-5352		17. INFORMANT (Son) Harry M. Siegle Jr. Address Maryland 75 Del Rio Rd. Dundalk,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Cancer of the stomach & metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) metastases DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1966 , to 1-9, 1967 , that (I) (we) last saw the deceased alive on 1-9, 1967 , and that death occurred at 10 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE Marcos Levin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/10/67		
22c. PHYSICIAN'S NAME (Type) Marcos Levin,					22d. ADDRESS M.D. 201 Wise Ave. Dundalk, Md. 21222				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/12/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John J. Duda					ADDRESS 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

000229

000229

15 Feb 1964
To: Mr. J. Edgar Hoover
From: Mr. J. Edgar Hoover
Subject: [illegible]
Re: [illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to you for your information and for your use in the Bureau.

Very truly yours,
J. Edgar Hoover
Director

Enclosure

100-100000-100000

100-100000-100000

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00427

CERTIFICATE OF DEATH

00430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 15 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland d. STREET ADDRESS 2002 Ruxton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Janet Alice SIMONS			4. DATE OF DEATH Month 1 Day 28 Year 1967														
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/49		9. AGE (In years last birthday) 17 yrs. <table border="1" style="float:right; font-size: small;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.													
13. FATHER'S NAME Howard Julian Simons			14. MOTHER'S MAIDEN NAME Patricia Jane Pratt														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic Necrotizing Pneumonia 3255 DUE TO Aspiration of Gastric Contents Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Marked mental Retardation, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH Wks Yrs 17yrs												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-31-1967 to 1-28-1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-28-1967 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.																	
22a. SIGNATURE Harry G. Butler M.D.					22b. DATE SIGNED 1-30-67												
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.					22d. ADDRESS Rosewood Lane, Owings Mills, Maryland												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/67		23c. NAME OF CEMETERY OR CREMATORY Roswood Cemetery													
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				25a. REC'D BY REGISTRAR DATE FEB 3 1967													
25b. REGISTRAR'S SIGNATURE Charles Judge				23d. LOCATION (City, town or county) (State) Owings Mills, Md.													

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00428

CERTIFICATE OF DEATH

00431

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 1 1/4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Deborah Middle Lynn Last SLETTTO		4. DATE OF DEATH Month 1 Day 13 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-63
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ellsworth Omar Sletto		14. MOTHER'S MAIDEN NAME Joanne Marie Tolerico	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONVULSIVE DISORDER 356.2 DUE TO (b) PROGRESSIVE MUSCULAR ATROPHY DUE TO (c) (WERDNIG-HOFFMAN SYNDROME)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-25 , 19 65 , to 1-13 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-13 , 19 67 , and that death occurred at 9:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE Harry G. Butler		22b. DATE SIGNED 1-13-67	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-1967	
23c. NAME OF CEMETERY OR CREMATORY GATE of HEAVEN CEM		23d. LOCATION (City or Town) (County) (State) Wheaton Mont Md	
24. FUNERAL DIRECTOR Robert A. Dool		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 23 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00429

CERTIFICATE OF DEATH

00432

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4018 Klausmier Road		d. STREET ADDRESS 4018 Klausmier Road	
3. NAME OF DECEASED (Type or print) JOHN W. SMITH First Middle Last		4. DATE OF DEATH Jan. 1 1967 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1902 9. AGE (In years lost birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance agent		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert J. Smith, Sr.		14. MOTHER'S MAIDEN NAME Katherine Busky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-07-2939	
17. INFORMANT Mrs Marie F Smith		Address 4018 Klausmier Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 177X IMMEDIATE CAUSE (a) Carcinoma of the prostate DUE TO (b) with generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH about 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 49 , to Jan , 19 67 , that (I) (we) lost the deceased alive on Jan 19 67 , and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Douglas Lockard		22b. DATE SIGNED 2 Jan, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Douglas Lockard		22d. ADDRESS Cockey's Mill Rd, Lanterbourne, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 1/5/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Baltimore, Md.		25a. REC'D BY REGISTRAR JAN 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00433

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Benson Ave. & Beltway Overpass		d. STREET ADDRESS Manhattan Beach Rd. 122	
3. NAME OF DECEASED (Type or print) First PAUL Middle WILLIAM Last SMITH		4. DATE OF DEATH Month 1 Day 7 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/44
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Smith		14. MOTHER'S MAIDEN NAME Vera Keimig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 819.4 IMMEDIATE CAUSE (a) Crushing Head Injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-fixed object accident	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:11 1 7 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.		22. DATE SIGNED 1/7/67	
EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/11/67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge	23d. LOCATION (City or Town) (County) (State) Elkridge Md
24. FUNERAL DIRECTOR McCully F M 237 Patapsco Ave 21225		25. REC'D BY REGISTRAR DATE JAN 9 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00431

MARYLAND STATE DEPARTMENT OF HEALTH

RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00434

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>UNK</u>		d. STREET ADDRESS <u>421 IL Chester Ave 21118</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Jane</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/19</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mose Dooley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen Cote Sears</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>26-12-6509</u>	
17. INFORMANT <u>Medical Records GBMC</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the breast Rt.</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Metastasis to ovaries & G.</u> DUE TO (c) <u>Generalized Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 years</u> <u>10 years</u> <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I (this hospital) attended the deceased from <u>Dec. 7, 1966</u> , to <u>Jan. 29, 1967</u> , that (II) (we) last saw the deceased alive on <u>Jan. 28, 1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ludilina M. Oteyza</u>		22b. DATE SIGNED <u>Jan. 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUDILINA M. OTEYZA</u>		22d. ADDRESS <u>GBMC - 6701 N. Charles, Balt. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR <u>McCULLY FUNERAL HOME 237 PATAPSCO AVENUE</u>		25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>			

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FILE IN W-2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00432					00435						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)						
a. COUNTY Baltimore County					a. STATE Maryland COUNTY Prince George						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson, Md.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					d. STREET ADDRESS 4703 Erie St.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Martha			Middle Curly's			Last Southall		
4. DATE OF DEATH			Month 1			Day 14			Year 1967		
5. SEX F			6. COLOR OR RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10.18.89		
9. AGE (In years last birthday) 77 yrs.			IF UNDER 1 YEAR Months 16			IF UNDER 24 HRS. Days 2			Hours 16		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Charles Macou Southall						14. MOTHER'S MAIDEN NAME Alice Mooers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. - -					
17. INFORMANT Records, Mt. Wilson State Hospital						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12.29, 1966 , to 1.14, 1967 , that (I) (we) last saw the deceased alive on 1.14.1967 , and that death occurred at 6:25 AM , from the causes and on the date stated above.											
22a. SIGNATURE Wm. Newcomer										22b. DATE SIGNED 1.14.67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent										22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan 17, 1967			23c. NAME OF CEMETERY OR CREMATORY Washington Memorial Park			23d. LOCATION (City, town or county) (State) Sampson Va		
24. FUNERAL DIRECTOR F Gascho sons Hyattsville, Md						25a. REC'D BY REGISTRAR DATE JAN 16 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

80432

00432

Baltimore County

Mount Wilson, Md.

Mount Wilson State Hospital

Records, Mount Wilson State Hospital

Mr. Newcomer, M.D., Superintendent, Mount Wilson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00433						00436					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Baltimore</i>						a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>						b. COUNTY <i>Baltimore</i>					
c. LENGTH OF STAY IN 1b <i>17 days</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>GREATER Baltimore Medical Center</i>						d. STREET ADDRESS <i>554 East 38th St.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <i>CLARA MAY SPIELMAN</i>						Month Day Year <i>Jan. 15 1967</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-12-81</i>		9. AGE (In years last birthday) <i>85 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Registered Nurse</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington Co., Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Spielman</i>						14. MOTHER'S MAIDEN NAME <i>Mary Joseph Phine</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Unknown</i>						16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>Patients Chart</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 422.1 DUE TO (b) <i>Arterio-sclerotic vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 30th</i> , 19 <i>66</i> , to <i>Jan. 15th</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Jan. 15th</i> , 19 <i>67</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>M. Isabelle MacGregor</i>						22b. DATE SIGNED <i>1-15-67</i>					
22c. PHYSICIAN'S NAME (Type) <i>M. MacGregor</i>						22d. ADDRESS <i>Greater Baltimore Medical Center</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1/18/67</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Hagerstown Md.</i>		
24. FUNERAL DIRECTOR <i>Robert H. Martin</i> <i>Preston H. Hunsicker</i>						25a. REC'D BY REGISTRAR <i>JAN 19 1967</i>					
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>											

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FOR STATE
HEALTH DEPT.

00434

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00437

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waren Road, 4 Mi. E. of York Road		d. STREET ADDRESS 3 Glenbrook Drive	
3. NAME OF DECEASED (Type or print) First MILTON Middle T. Last SPILLERS		4. DATE OF DEATH Month 1 Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/24
9. AGE (In years lost birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 1 Days 8 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY FOOD STORE	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Spillers		14. MOTHER'S MAIDEN NAME Tula Rackley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 260-03-2152	
17. INFORMANT Mrs. Velma T. Spillers		Address 3 Glenbrook Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral Injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-fixed object accident.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1 7 1967 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Phoenix		(County) Baltimore (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker		M.D.	
EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		22. DATE SIGNED 1/8/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/67	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Rd. 21204	
25a. REC'D BY REGISTRAR JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00032

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

1 (M)

00435

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00438

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN c. LENGTH OF STAY IN 1b 6 YRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2013 KERNAN DRIVE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN d. STREET ADDRESS 2013 KERNAN DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA VERL STAUFFER		4. DATE OF DEATH Month Day Year JAN 1 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 9, 1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) DANIELS MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN ENGLE		14. MOTHER'S MAIDEN NAME SOPHIE ? (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219014967	
17. INFORMANT MRS WILLIAM LINE		Address SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTEROSCLEROTIC HEART DISEASE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c) 1 MON.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John N. Snyder EXAMINER'S NAME (Type) JOHN N. SNYDER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6348 FREDERICK RD.	
22. DATE SIGNED 1/2/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-4-1967	
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City or Town) (County) (State) Howard Co. Md.	
24. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.,	
25a. REC'D BY REGISTRAR JAN 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00033

MEDICAL TRAINING CENTER OF TEXAS

00033

1/1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00436

00439

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 03-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 Mellinee Avenue				d. STREET ADDRESS 7118 Walnut Avenue			
3. NAME OF DECEASED (Type or print) LAURA GEORGIA ANN STEPNEY				4. DATE OF DEATH January 25, 1967 pronounced Month Day Year			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/1891	9. AGE (In years last birthday) yrs. 75	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Whiten				14. MOTHER'S MAIDEN NAME Georgianna Whiten			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Lillian Hall 7118 Walnut La. PKS. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		January 26, 1967	
Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 130/67		23c. NAME OF CEMETERY OR CREMATORY Saint Thomas Cem		23d. LOCATION (City or Town) (County) (State) Randallstown Md.	
24. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave. Balt.				25a. REC'D BY REGISTRAR DATE JAN 31 1967		25b. REGISTRAR'S SIGNATURE Charles Springate	

00439

00439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
00437		CERTIFICATE OF DEATH	
00440			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>6 Mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>4626 Manordene Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JULIA BROTHERTON STEVENS</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1873</u>
9. AGE (In years lost birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Cole Brotherton</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Moore Mattingly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-4254</u>	
17. INFORMANT <u>Mrs. Sarah S. Duffy</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 19 <u>50</u> , to <u>Jan 19</u> , 19 <u>67</u> that (I) (<u>we</u>) lost saw the deceased alive on <u>Jan 19</u> , 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>C. Mendelis</u> M.D.		22b. DATE SIGNED <u>1-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Christopher Mendelis</u>		22d. ADDRESS <u>2308 Edmondson Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-23-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u> <u>6500 York Rd. Baltimore, Md. 21212</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00437

00430

Carroll's Foot Locker
Lithia Springs

Jan 17 1956
Jan 15 1956
Jan 11 1956
1-21-56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00438					00441				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u> c. LENGTH OF STAY IN 1b <u>69 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>BALTIMORE</u> b. COUNTY <u>MARYLAND</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30.4</u> d. STREET ADDRESS <u>1345 HERKIMER ST 3316 LAKE AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ROSALIE D. STIEGMANN</u>			4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1967</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <u>9-28-97</u>			9. AGE (In years last birthday) <u>69 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME <u>John Raymond DUFFY</u>			14. MOTHER'S MAIDEN NAME <u>MARY ROSA LEE DUFFY O'BRIEN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>218-01-5171</u>		17. INFORMANT <u>FAMILY - 3316 LAKE AVE.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RHEUMATIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>416X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMBOLI & BRONCHOPNEUMONIA</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>67</u> , to <u>1-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Evelyn L. Ramos M.D.</u>			22b. DATE SIGNED <u>1-23-67</u>		22c. PHYSICIAN'S NAME (Type) <u>EVELYN L. RAMOS, M.D.</u>				
22d. ADDRESS			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWBROOK MEMORIAL</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. MD</u>		
24. FUNERAL DIRECTOR <u>J. Walter Cook</u>			24a. ADDRESS <u>5444 BELAIR RD.</u>		24b. REC'D BY REGISTRAR <u>JAN 27 1967</u>		24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

RESUMATIVE HEART DISEASE

Revised Chapter 1 of the Constitution

ELVIN J. RAMOS M.D.
Bryan L. Jones Jr.

FD ES-1 70 21-1 70 ES-1
70-ES-1 X 70-ES-1

00439

CERTIFICATE OF DEATH

00442

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ivy Hall Nursing Home</u>		d. STREET ADDRESS <u>33 Cliffwood Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Mignon C Stottlemeyer</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1891.</u>
9. AGE (In years less birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Carson</u>		14. MOTHER'S MAIDEN NAME <u>Loretta Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-1911DC</u>	
17. INFORMANT <u>James Stottlemeyer</u>		Address <u>Glen Arm, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1966</u> , to <u>Jan 2, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 2, 1967</u> and that death occurred at <u>4:40 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. Baumgardner</u> M.D.		22b. DATE SIGNED <u>1/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>		22d. ADDRESS <u>Balto 6 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/5/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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How's it going?

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1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 26

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CERTIFICATE OF DEATH

00443

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>		c. LENGTH OF STAY IN lb <u>4 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite 1317</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto County Hospital</u>				d. STREET ADDRESS <u>St Paul Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>F.</u> Last <u>Strehle</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/1909</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Jacob Strehle</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Telzman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>050 12 1964</u>		17. INFORMANT <u>Mrs. Dorothy Strehle - Abadstock, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> DUE TO (b) <u>Phlebitis left lower extremity</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injured while working</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Balto.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>67</u> , to <u>1/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/26</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Samuel J. Abrams</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel J. Abrams</u>				22d. ADDRESS <u>7220 Park Heights Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-28-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto.</u> <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Houghton Sponsoring</u>				25a. REC'D BY REGISTRAR DATE <u>Jan 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00443

CENTROPEDE OF DEATH

00443

00443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00441		CERTIFICATE OF DEATH				00444				
1. PLACE OF DEATH a. COUNTY <u>BALT. MORE CO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			c. LENGTH OF STAY IN 1b <u>23 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Westminster 3452 Rd</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AGED WOMENS & AGED MENS Home</u>					d. STREET ADDRESS <u>3452 Reswick Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>DENTON</u> Last <u>SULLIVAN</u>					4. DATE OF DEATH Month <u>JAN</u> Day <u>17</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 1, 1876</u>		9. AGE (In years last birthday) <u>91</u> Yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jessie Sullivan</u>					14. MOTHER'S MAIDEN NAME <u>Amelia Brown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>219-12-9107A</u>		17. INFORMANT <u>Horis Sherman 615 Chestnut Ave Towson</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>A.S.C.U.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 18</u> , 19 <u>44</u> , to <u>Jan. 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>Newland E. Day</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 18, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Newland E. Day</u>					22d. ADDRESS <u>4-E-33rd St Baltimore Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KRIDER CEMETERY</u>			23d. LOCATION (City or Town) (County) (State) <u>Westminster MARYLAND</u>			
24. FUNERAL DIRECTOR <u>Am. Cook-Brooks Towson Inc.</u>					ADDRESS <u>1650 YORK Rd. Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00044

WEST AVE. OF DEATH

00044

A 2 C ND

Wardlaw E. Day

H-3-334 27 Bellamy Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00442

Item 23b Film G384 1/11/67 mh

CERTIFICATE OF DEATH

00445

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 47 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21231		d. STREET ADDRESS 1906 BANK STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Ludwik) LOUIS First Middle Last KASPER SZYMANOSKI		4. DATE OF DEATH Month JANUARY Day 4 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 18, 1895
9. AGE (In years lost birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK SZYMANOSKI (Szymanowski)		14. MOTHER'S MAIDEN NAME CECELIA PISARSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 30 72 24	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 584X IMMEDIATE CAUSE (a) CHOLELITHIASIS, INTERMITTENT COMMON DUCT DUE TO OBSTRUCTION, ASCENDING INFECTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/18/66 , 19__ to 1/4/67 , 19__, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 1/4/67 , 19__, and that death occurred at 3:15 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick M.D.</i>		22b. DATE SIGNED 1/4/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jan. 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		23d. LOCATION (City or Town) (County) (State) BERMAN HILL RD. BALTO. MD.	
24. FUNERAL DIRECTOR <i>Charles D. Sadowski</i>		25. REC'D BY REGISTRAR JAN 6 1967	
25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00443						00446						
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21212 30.4						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph Hospital						d. STREET ADDRESS 1103 E. Belvedere Ave/				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Elmer Middle N. Last Taylor			4. DATE OF DEATH Month Jan. Day 15 Year 1967			5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-27-98			9. AGE (In years last birthday) 68 yrs.			10. UNDER 1 YEAR Months _____ Days _____			11. UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainmaster				10b. KIND OF BUSINESS OR INDUSTRY Pa.R.R.		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William B. Taylor						14. MOTHER'S MAIDEN NAME Mary A. Fairborne						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. _____		17. INFORMANT Elizabeth C. Taylor			Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm of abdominal aorta. DUE TO (b) Atherosclerosis. DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
INTERVAL BETWEEN ONSET AND DEATH												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 15, 1967 to Jan. 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 15, 1967 , and that death occurred at 9:35 PM , from the causes and on the date stated above.												
22a. SIGNATURE M.S. Cockburn M.D.						22b. DATE SIGNED January 16, 1967			22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.			
22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-19-67		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town or county) (State) Parkville Md.				
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						25a. REC'D BY REGISTRAR JAN 19 1967		25b. REGISTRAR'S SIGNATURE Charles Jones				

2322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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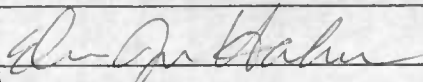
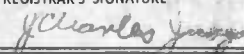
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00444

CERTIFICATE OF DEATH

00447

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 15 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 2336 EDMONDSON AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle - - - Last TAYLOR		4. DATE OF DEATH Month JANUARY Day 29 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14, 1897
9. AGE (In years lost birthday) yrs. 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEELWORKER	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) KING WILLIAM COUNTY, VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE TAYLOR	
14. MOTHER'S MAIDEN NAME PEACHIE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO. 212 01 92 09		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) COR PULMONALE AND PULMONARY EMPHYSEMA DUE TO (c) CONGESTIVE CARDIAC FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS YEARS MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 14 , 19 67 , to JAN. 29 , 19 67 that (I) (we) last saw the deceased alive on JAN. 29 , 19 67 , and that death occurred at 500P M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 1-29-67	
22c. PHYSICIAN'S NAME (Type) WON JU HAHN, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-3-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SCHROEDER AND BRANTLEY AVE, BALTIMORE, MD.		25a. REC'D BY REGISTRAR FEB 1 1967	
25b. REGISTRAR'S SIGNATURE 			

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

BP

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G385 2/8/67 mh

00445

CERTIFICATE OF DEATH

00448

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 20 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		12.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS Box 282 Route 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence S. Thompson		4. DATE OF DEATH Month January Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 84 yrs.
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 11 Hours 54 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James S. ? Beale		14. MOTHER'S MAIDEN NAME unknown Susan Wilgis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition & Dehydration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Gastric malignancy DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1966 , to Jan. 2, 1967 , that (I) (we) last saw the deceased alive on January 2, 1967 , and that death occurred at 12:20 PM , from causes and on the date stated above.			
22a. SIGNATURE A. Taheri		22b. DATE SIGNED January 2, 1967	
22c. PHYSICIAN'S NAME (Type) Amanollah Taheri		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/67.	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Jountain Green, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATE OF TEXAS

1900

County

City

State

Year

Age

Sex

Box 100 - House 1

Spring Grove Hospital

Thompson

Johnson

1-1-1900

XX

Male White

Married

Housewife

1. 1900

Report: Spring Grove State Hospital

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Spring Grove State Hospital

Spring Grove State Hospital

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CERTIFICATE OF DEATH

Reg. Dist. No.

00449

00446

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1523 Kirkwood Rd.		d. STREET ADDRESS 1523 Kirkwood Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph W. Tillen		4. DATE OF DEATH Month Day Year Jan. 18 19 67	
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-96
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - Joseph Tillen		14. MOTHER'S MAIDEN NAME Late - Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 212-03-0155	
17. INFORMANT Mrs. Eva Tillen 1523 Kirkwood Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 3, 1959 , to Jan 18, 1967 , that I last saw the deceased alive on Jan 17, 1967 , and that death occurred at 8 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Kennard Yaffe		ADDRESS (Street, city or town, state) 5501 Forest Park Ave.	
PHYSICIAN'S NAME (Type) Kennard Yaffe		DATE SIGNED 1/19/67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-67	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE Jan 19 1967	
24b. REGISTRAR'S SIGNATURE f Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00447

CERTIFICATE OF DEATH

00450

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. County General</u>		d. STREET ADDRESS <u>3307 Offutt Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Tillett, Frank</u>		4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>(W)</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>March 7, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	9. AGE (In years last birthday) <u>69</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Charles Town, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Tillett</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-7434</u>	
17. INFORMANT <u>Mrs. Annie M. Tillett-3307 Offutt Rd.</u>		Address <u>Randallstown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>151X</u> IMMEDIATE CAUSE (a) <u>acute cardiovascular failure</u> DUE TO (b) <u>stroke</u> DUE TO (c) <u>adenocarcinoma spread of meta</u>			INTERVAL BETWEEN ONSET AND DEATH <u>56</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-20, 1966</u> , to <u>1-17, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> 19 <u>67</u> , and that death occurred at <u>2:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. De Joya</u>		22b. DATE SIGNED <u>1/17/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Balto. County Gen. Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	23d. LOCATION (City or Town) (County) (State) <u>Randallstown, Md. 21133</u>
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00450

STATE OF TEXAS

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County of ...

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00448

CERTIFICATE OF DEATH

00451

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN TB 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First John Middle Daniel Last Todd, Jr.			4. DATE OF DEATH Month Jan. Day 2 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/8/04		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Somerset - Maryland	
13. FATHER'S NAME John Daniel Todd			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none none		16. SOCIAL SECURITY NO. none		17. INFORMANT Records Rosewood State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible malignancy, site unknown DUE TO 351X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Defect, Congenital DUE TO (c) Dyslexia					INTERVAL BETWEEN ONSET AND DEATH Birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hydrocephalus, secondary					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-3 , 19 17 , to 1-2 , 19 67 , that (I) (we) lost saw the deceased alive on 1-2 19 67 , and that death occurred at 10:35 AM , from causes and on the date stated above.					
22a. SIGNATURE Joyce M. Boyd			22b. DATE SIGNED 1-2-67		22c. PHYSICIAN'S NAME (Type) Joyce M. Boyd, M.D.
22d. ADDRESS Rosewood State Hospital, Owings Mills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF Jan. 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
23d. LOCATION (City or Town) (County) (State) Baltimore City, Md.					
24. FUNERAL DIRECTOR Wm. Cook - Brooks Inc. 1217 St. Paul St.		25a. REC'D BY REGISTRAR DATE JAN 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15400

02500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00449

00452

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)																			
c. LENGTH OF STAY in lb				<i>Baltimore</i> 30.4																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Towson Convalescent Home Chesapeake</i>				d. STREET ADDRESS <i>Cambridge Arms Apt</i>																			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Margaret ANN Toner</i>				4. DATE OF DEATH Month Day Year <i>Jan. 8 1967</i>																			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 11 1882</i>		9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher - Homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>A. A. Co., Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>											
13. FATHER'S NAME <i>Albert Murphy</i>				14. MOTHER'S MAIDEN NAME <i>Mary Herman</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>216-46-3211</i>				17. INFORMANT: Son (and T.C.H. Records) <i>burgh, Pa.</i> <i>Arthur C. Toner, Jr. King Edward Apt., Pitts-</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 491X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Cerebral Arteriosclerosis</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <i>January 19 55</i> to <i>Jan 8 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan 7 1967</i> , and that death occurred at <i>10:20 P</i> M, from the causes and on the date stated above.																							
22a. SIGNATURE <i>Lester A. Wall Jr</i>												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>1/8/67</i>							
22c. PHYSICIAN'S NAME (Type) <i>LESTER A. WALL JR</i>												22d. ADDRESS <i>1039 St Paul St Baltimore Md</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>1/11/1967</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery Woodlawn, Balto. Co., Md.</i>				23d. LOCATION (City, town or county) (State)											
24 FUNERAL DIRECTOR'S SIGNATURE <i>Stewart & Mowen Co., 108 W. North Av., City 1</i>												ADDRESS				25a. REC'D BY REGISTRAR <i>JAN 11 1967</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

00440

00440

Baltimore

Thompson

Baltimore

Town Councilman, New England, Cambridge, Mass. City

Thompson

Town

Jan

Jan 11 1872

Tracy - Thompson

Albert Thompson

Thompson

Thompson

Thompson

John A. Thompson

Letter A. Wall Jr

Jan 10 1872

1

1/10/72

1037 St. Louis St. Baltimore, Md

Jan 11 1872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00450

CERTIFICATE OF DEATH

00453

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2918 E Pratt St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Dorothy Gertrude Trautner</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/24/08</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours <u>19</u> Min. <u>67</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Adam Andrew Trautner</u>				14. MOTHER'S MAIDEN NAME <u>Feldman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>-</u>				16. SOCIAL SECURITY NO. <u>214-40-7167</u>				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH. <u>10 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14</u> , 19 <u>66</u> , to <u>Jan. 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 2</u> , 19 <u>67</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>S. M. OTEYLA, M.D.</u>												22b. DATE SIGNED <u>Jan. 2, 1967</u>							
22c. PHYSICIAN'S NAME (Type) <u>L. M. OTEYLA</u>												22d. ADDRESS <u>GBMC - Charles St. Balt. M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-5-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>				23d. LOCATION (City, town or county) (State) <u>Mel. Balto.</u>							
24. FUNERAL DIRECTOR <u>Thelma A. Hoffmann</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>JAN 4 1967</u>							

00022

00020

Barthmore
Barthmore

Barthmore
Barthmore

Greater Baltimore Medical Center 2218 E Pratt St

1/24/08 28
Dorothy Gentry Trotter

Teacher
School
Barthmore Hg. USA
Alan Andrew Trotter
7/2/08
BM-10-1102

Michael's Great Lanes

Jan 14 2008
Jan 14 2008
Jan 14 2008

Jan 14 2008
Jan 14 2008
Jan 14 2008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

SISTER GERARD										MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										00454														
00451										CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY BALTIMORE					b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARRIOTTSVILLE					c. LENGTH OF STAY IN 1b 13.1					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD.					b. COUNTY BALTO.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BONSECOURS PROVINCIAL HOUSE										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) SISTER GERARD MAJELLA TREACY					4. DATE OF DEATH Month JAN. Day 11 Year 1967					5. SEX F					6. COLOR OR RACE W									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					8. DATE OF BIRTH JULY 2, 1884					9. AGE (In years last birthday) 82 yrs.					IF UNDER 1 YEAR Months 8 Days 2 Hours 0 Min. 0									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE					10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS					11. BIRTHPLACE (County & State, or foreign country) IRELAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME EDMUND TREACY										14. MOTHER'S MAIDEN NAME NORA RYAN														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. ---					17. INFORMANT Mother - BONSECOURS Sister					Address ---									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 490X (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---															INTERVAL BETWEEN ONSET AND DEATH 7 DAYS									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ---																								
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---					20f. (City or town) (County) (State) ---									
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 --- , to 1/13 , 19 67 , that (I) (we) last saw the deceased alive on 1/10/67 19 --- , and that death occurred at 4:45 PM , from the causes and on the date stated above.																								
22a. SIGNATURE Hubert W. Lamm, M.D.										22b. DATE SIGNED 1/14/67					22c. PHYSICIAN'S NAME (Type) Hubert W. Lamm, M.D.									
22d. ADDRESS 4804 FREDERICK BLVD										22e. REC'D BY REGISTRAR ---					22f. REGISTRAR'S SIGNATURE Charles Judge									
23a. BURIAL, CREMATION, REMOVAL (Specify) ---					23b. DATE THEREOF 1-16-67					23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.					23d. LOCATION (City, town or county) (State) Balto. Md.									
24. FUNERAL DIRECTOR Farley - Covington & S.H. - Catonsville Md.																								
25a. REC'D BY REGISTRAR JAN 18 1967																								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20.M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
00452			CERTIFICATE OF DEATH		
00455			00455		
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 58 DAYS			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO Co c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2811 DELAWARE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ARTHUR Middle ELMER Last TRIPP			4. DATE OF DEATH Month JANUARY Day 4 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/05	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME EVERHART TRIPP			14. MOTHER'S MAIDEN NAME ROSA WEBER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 219 10 75 82		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO 356.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AMYOTROPHIC LATERAL SCLEROSIS DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRONCHITIS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/7/66 , 19__, to 1/4/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/4/67 , 19__, and that death occurred at 5:40 PM from causes and on the date stated above.					
22a. SIGNATURE Carmelita A. Cendana			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/4/66
22c. PHYSICIAN'S NAME (Type) CARMELITA A. CENDANA, M. D.			22d. ADDRESS VAH FORT HOWA RD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/9/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS MC CULLY FUNERAL HOME		25a. REC'D BY REGISTRAR JAN 6 1967 DATE FOR TOWN & LIGHT STS. BALTO. MD.	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

\$2200

James A. Gordon

1902

00453

CERTIFICATE OF DEATH

00456

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 172 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 3302 CLARKS LANE, APT 30.4 1909 HARBOR ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BARNEY Middle S. Last TUCKER			4. DATE OF DEATH Month JANUARY Day 17 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/06		9. AGE (In years last birthday) yrs. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAKER		10b. KIND OF BUSINESS OR INDUSTRY JEWELRY STORE		11. BIRTHPLACE (County & State, or foreign country) NEW YORK, N. Y.	
13. FATHER'S NAME HYMAN TUCKER			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 218 22 59 63		17. INFORMANT CLIN. RECORDS, VA HOSPITAL. FT HOWARD, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT LOWER LOBE PNEUMONIA, UNDETERMINED ORGANISM DUE TO (b) — DUE TO (c) BRAIN TUMOR, LEFT CEREBAL, UNCLASSIFIED TYPE					INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RUPTURE OF MID ESOPHAGUS. BENIGN PROSTATIC HYPERTROPHY					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/29/66 , 19 67 , to 1/17/67 , 19 67 , that 4 (we) last saw the deceased alive on 1/17/67 , 19 67 , and that death occurred at 10:15AM , from causes and on the date stated above.					
22a. SIGNATURE <i>Neilson Neilson</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/18/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/19/67		23c. NAME OF CEMETERY OR CREMATORY Maryland Free State Jewish War Veterans Cemetery Rosedale, Maryland	
24. FUNERAL DIRECTOR		ADDRESS Sol Levinson & Sons		25a. REC'D BY REGISTRAR JAN 23 1967	
		DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. REGISTERSTOWN RD. BALTIMORE, MD.					

00452

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00457				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2499 1/2 Fairway					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 21222 d. STREET ADDRESS 2499 1/2 Fairway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EDMUND Middle HARWOOD Last TURNER					4. DATE OF DEATH Month January Day 14th Year 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1923		9. AGE (in years last birthday) 43 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright				10b. KIND OF BUSINESS OR INDUSTRY Tel. Mfrgr.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George G. Turner					14. MOTHER'S MAIDEN NAME Emma K. Knoble				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WWII - Korea					16. SOCIAL SECURITY NO. 219-18-4854		17. INFORMANT Loretta H. Turner, same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) Obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Obesity									INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Theodore C. Patterson					22. DATE SIGNED 1/14/67				
EXAMINER'S NAME (Type) Theodore C. Patterson, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Dundalk, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/18/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co., Maryland		
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.					25a. REC'D BY REGISTRAR JAN 16 1967				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00455					00458				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY <i>Baltimore</i>					a. STATE <i>MD</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>					b. COUNTY <i>Baltimore</i>				
c. LENGTH OF STAY IN 1b <i>1 1/2 hrs.</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Baltimore County General</i>					d. STREET ADDRESS <i>6628 Sanzo Rd</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print) First Middle Last <i>MILTON UHLFELDER</i>					Month Day Year <i>JAN 29 1967</i>				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<i>M</i>		<i>W</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>6-27-04</i>		<i>62</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>David Uhlfelder</i>					14. MOTHER'S MAIDEN NAME <i>Rosa ?</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>215-24-6426</i>		17. INFORMANT <i>Mrs. Sara Uhlfelder, 6628 Sanzo Rd.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>one year</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>one year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Mar 1946</i> , to <i>Jan 29, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan 29, 1967</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Samuel V. Tomparov</i>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Jan 29, 1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>SAMUEL V. TOMPAROV, MD</i>					22d. ADDRESS <i>3600 PARK HEIGHTS AVE</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1/30/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR <i>Sol Levinson & Bros. Inc., 6010 Reisterstown</i>					25a. REC'D BY REGISTRAR <i>FEB 2 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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UNL FELDER

WILLIAM

Washington, Maryland

David and John

212-4-4400

Orthodontic Center Inc

Jan 11 1971

Handwritten signature

3000 Park Heights Ave

Washington, Maryland

212-4-4400

For information & Bros. Inc., 3010 Pennsylvania

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
Item 23b Film G385 1/31/67 mh					
00456			00459		
1. PLACE OF DEATH a. COUNTY BALTIMORE			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 38 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIVALVE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle INGOLF Last VALENTINE			4. DATE OF DEATH Month JANUARY Day 23 Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/12	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RETIRED SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U. S. ARMY		11. BIRTHPLACE (County & State, or foreign country) GRASS RANGE, MONTANA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME RICHARD E. VALENTINE			14. MOTHER'S MAIDEN NAME AGNES RASSMUSSEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1955 - 1960		16. SOCIAL SECURITY NO. 577 28 99 08	17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO INFARCTION OF MYOCARDIUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBOSIS OF CORONARY ARTERIES DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE					INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from 12/16/66 , 19__ to 1/23/67 , 19__, that (1) (we) last saw the deceased alive on 1/23/67 , 19__, and that death occurred at 7:20A M, from causes and on the date stated above.					
22a. SIGNATURE J. Fabara			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/23/67
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.			22d. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/26/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA		
24. FUNERAL DIRECTOR Mr. R.B.			25a. REC'D BY REGISTRAR DATE JAN 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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JOHN A. KERRY, JR.

ADDITIONAL INFORMATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00457

CERTIFICATE OF DEATH

00460

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 43 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1827 REDWOOD AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY LEE VAN HORN		4. DATE OF DEATH Month Day Year JANUARY 1 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 17, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAYMASTER		10b. KIND OF BUSINESS OR INDUSTRY FACTORY	
11. BIRTHPLACE (County & State, or foreign country) PITTSBURGH, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIUS VAN HORN		14. MOTHER'S MAIDEN NAME CLARA HOBURG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 214 01 36 27	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 ESOPHAGEAL VARICES AND ULCERATION WITH HEMORRHAGE DUE TO (b) CIRRHOSIS OF LIVER DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA, BILATERAL AND GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV 19 , 19 66 , to JAN 1 , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JAN 1 , 19 67 , and that death occurred at 650A M. from causes on and the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 1/3/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION CRS. BURIAL		23b. DATE THEREOF JAN. 6, 1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR John Burns' Sons		25a. REC'D BY REGISTRAR DATE JAN 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00458

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G384

1/17/67 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00461

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>244</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <u>Baltimore</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSP.</u>				d. STREET ADDRESS <u>222 W. Lafayette St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First (Wills) Middle Last <u>THOMAS W. VICKERS</u>				4. DATE OF DEATH Month Day Year <u>Jan. 10 1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/1923</u>	9. AGE (In years lost birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE R. VICKERS III</u>				14. MOTHER'S MAIDEN NAME <u>HELEN M. THOMAS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHART</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SCHIZOPHRENIA</u> DUE TO <u>2) CATATONIA</u> (b) <u>3) EPILEPSY</u> DUE TO <u>1) ASPIRATION OF FOOD</u> due to (c) <u>1; 2; 3</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <u>7:00 PM</u>							
ACTUAL SIGNATURE <u>E. Kasari</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>1/10/67</u>	
EXAMINER'S NAME (Type) <u>E. KASARI, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>STEWART & MOWEN CO., 108 W. North Av., Balto.</u>				25a. REC'D BY REGISTRAR <u>Charles Juerg</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Juerg</u>	

12200

12200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00459

00462

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE COUNTY</u>		c. LENGTH OF STAY IN lb <u>90</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03.1</u> <u>BALTIMORE COUNTY, MARYLAND</u>		d. STREET ADDRESS <u>8141 LOCKRAVEN BRO. BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>na</u> <u>8141 LOCKRAVEN BRO. BALTIMORE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>MARY</u> Last <u>VOELKIER</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/1877</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>ADAM MUELLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HEIL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-7481</u>	
17. INFORMANT <u>MRS. MARY DAUGHTER BROWN</u>		Address <u>BALTIMORE 4</u> <u>8141 LOCKRAVEN BRO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>ACUTE CVA</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS GENERAL</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>20 YEARS</u> <u>20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>no</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that <u>(1) (his hospital)</u> attended the deceased from <u>7/1</u> , 19 <u>60</u> , to <u>1/21</u> , 19 <u>67</u> , that (1) <u>(we)</u> last saw the deceased alive on <u>1/20</u> , 19 <u>67</u> , and that death occurred at <u>12:50</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>A. Margaret Zaneckaus</u>		22b. DATE SIGNED <u>1/21/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ATTENDING PHYSICIAN, INTERNAL MEDICINE SELF-EMPLOYED</u>		22d. ADDRESS <u>7028 BELLONA AVE BALTIMORE 12, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/24/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Dippel Bro's. Inc. 7110 Belair Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

12/25/

1210

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00460

CERTIFICATE OF DEATH

00463

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN IT <u>9 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4301 Roland Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mabel C. Wachter</u>		4. DATE OF DEATH <u>1 14 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/81</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days 10 14 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Columbus, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Carlton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-1644</u>	
17. INFORMANT <u>Hospice records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>1221</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/28/66</u> to <u>Jan 14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Jan 13</u> , 19 <u>67</u> , and that death occurred at <u>5:18P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank J. Keuhn</u> M.D.		22b. DATE SIGNED <u>1/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank Keuhn, M.D.</u>		22d. ADDRESS <u>Medical Arts. Bldg, Balto., Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road Baltimore 12, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 17 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00462

CERTIFICATE OF DEATH

00464

1. PLACE OF DEATH a. COUNTY Maryland, Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN lb 1mth2ldys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Captiol Heights, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 6118 Central Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alburb Middle B. Last Waller				4. DATE OF DEATH Month January Day 16 Year 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1907		9. AGE (In years lost birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. L. Waller				14. MOTHER'S MAIDEN NAME Mattie ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of the epiglottis 1992 DUE TO and pharynx, with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (x) (this hospital) attended the deceased from Nov. 25, 1966 , to Jan. 16, 1967 , that (x) (we) last saw the deceased alive on Jan. 16, 1967 , and that death occurred at 10:10 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Stella Wachslar</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-17-67			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/19/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland			
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Road, Suitland Md.				25a. REC'D BY REGISTRAR DATE JAN 20 1967		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

00462

00462

STATE OF TEXAS

County of ...

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00463

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00465

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>		c. LENGTH OF STAY IN lb <u>2 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1252 STEVENS AVE</u>			d. STREET ADDRESS <u>1252 STEVENS AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MARGARET VIOLA WALTZ</u> First Middle Last			4. DATE OF DEATH <u>JAN 12 1967</u> Month Day Year		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>DEC 6 1891</u> <u>FEB 19 1917</u>		9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDRY WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>		11. BIRTHPLACE (State and foreign country) <u>CARROLL COUNTY MD.</u>	
13. FATHER'S NAME <u>ISAAC FRIZZELL</u>			14. MOTHER'S MAIDEN NAME <u>EMMA BARNES</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215056523</u>		17. INFORMANT <u>MRS HELEN WOLF BALTORES MD</u> Address <u>536 ALDON ST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DIS.</u> DUE TO (c) <u>HYPERTENSION.</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John N. Snyder</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>1/12/67</u>	
EXAMINER'S NAME (Type) <u>JOHN N. SNYDER M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county) <u>6348 FREDERICK RD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/16/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Taylorsville Cemetery</u>	
				23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 16 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00466

CERTIFICATE OF DEATH

00466

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 2 1/2 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1925 N. DIVISION STREET	
3. NAME OF DECEASED (Type or print) First CHARLES Middle F. Last WARFIELD		4. DATE OF DEATH Month JANUARY Day 9 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1902
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET CLEANER		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY	
11. BIRTHPLACE (County & State, or foreign country) HARFORD COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WARFIELD		14. MOTHER'S MAIDEN NAME GAROW SHEPHERD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 705 10 31 27	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRAPERITONEAL HEMORRHAGE DUE TO LIVER CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN DEATH HOURS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/9/67 , 19 67 , to 1/9/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/9/67 , 19 67 , and that death occurred at 12:20 PM , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 1/9/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-13-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>[Signature]</i>		25a. REC'D BY REGISTRAR DATE JAN 16 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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JOHN HOWARD

1947 A. DIVISION REPORT

VETERANS ADMINISTRATION HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

00465

CERTIFICATE OF DEATH

00467

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY in 1b 133 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2810 ALLENDALE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle -- Last WARNER		4. DATE OF DEATH Month JANUARY Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 8, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 59 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD WARNER		14. MOTHER'S MAIDEN NAME FLORENCE JENNINGS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 219 01 68 89	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 161X (b) ABSCCESS OF LEFT UPPER LOBE (c) 6021			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS WITH BILATERAL ADHESIONS, CLINICAL			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/31/66 , 19__ to 1/11/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/11/67 , 19__, and that death occurred at 12:20AM on 1/11/67 from causes and on the date stated above			
22a. SIGNATURE John D. Talbert		22b. DATE SIGNED 1/12/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-16-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR Charles R. Law		25a. REC'D BY REGISTRAR 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME CHARLES JUDGE	

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CERTIFICATE OF DEATH

00468

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21234 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 2605 Joppa Terrace	
3. NAME OF DECEASED (Type or print) First FIELDING Middle L. Last WATKINS		4. DATE OF DEATH Month Jan. Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/96
9. AGE (In years lost birthday) yrs. 70		10. IF UNDER 1 YEAR Months 25 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Watkins		14. MOTHER'S MAIDEN NAME Anna Caskey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-1961	
17. INFORMANT Mrs. Louise H. Watkins		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with multiple metastases. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/Dec. , 19 66 , to Jan. 25 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 25 , 19 67 , and that death occurred at 6:05 PM , from causes on and on the date stated above.			
22a. SIGNATURE <i>M.S. Cockburn M.D.</i>		22b. DATE SIGNED January 26, 1967	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/30/67.	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE JAN 26 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

00461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00469

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7817 W. Collingham Road Apt. D		d. STREET ADDRESS 7817 W. Collingham Road, Apt. D	
3. NAME OF DECEASED (Type or print) JOHN ROBERT WEAVER		4. DATE OF DEATH Month January Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> separated DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1912
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Weaver		14. MOTHER'S MAIDEN NAME Marie M. Meckes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212074770	
17. INFORMANT G. E. Weaver		Address 1915 Northbourne Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED January 16, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		23. DATE SIGNED January 16, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1-19-67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		25. REC'D BY REGISTRAR JAN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00467

00470

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE OF THE PINES, CATONSVILLE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1920 WILMINGTON AVE.	
3. NAME OF DECEASED (Type or print) AUGUST George		4. DATE OF DEATH Month 1 Day 16 Year 1967	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Color Matcher		10b. KIND OF BUSINESS OR INDUSTRY Davis Paint Co.	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME Otto Weibe		14. MOTHER'S MAIDEN NAME Bessie M. Carson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-4253	
17. INFORMANT Mrs. Margaret R. Weibe		Address 1920 WILMINGTON AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 260X DUE TO (b) DIABETES MELLITUS DUE TO (c) BROEN OAS PNEU MONIA			INTERVAL BETWEEN ONSET AND DEATH 1 mo years days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-19-1966 to 1-16-1967 , that (I) (we) last saw the deceased alive on 1-16-1967 , and that death occurred at 2:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Manuel J. Rodriguez		22b. DATE SIGNED 1-16-67	22c. PHYSICIAN'S NAME (Type) MANUEL J. RODRIGUEZ MD
22d. ADDRESS 435 CHARFONTE DR BALTO 28 MD		22e. REC'D BY REGISTRAR Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-19-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
23d. LOCATION (City, town or county) Baltimore, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 WILKENS AVENUE 21229	

00000

CERTIFICATE OF DEATH

00000

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6

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00468

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00471

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Blenheim Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELVIN E. Whims</u>		4. DATE OF DEATH Month Day Year <u>1/6/67</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/05</u> 61 yrs.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Leo Whims</u>	
14. MOTHER'S MAIDEN NAME <u>Matilda ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>20000</u>		17. INFORMANT <u>Annie M. Whims Phoenix, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Cardio-Renal</u> DUE TO (c) <u>Vascular Disease</u> stating the underlying cause last. <u>Parasitosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs +</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		22. DATE SIGNED <u>1/7/67</u>	
EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smt. Iron</u>	23d. LOCATION (City or Town) (County) (State) <u>Longgreen, Balto Co. Md.</u>
24. FUNERAL DIRECTOR <u>W. L. Whitman - 1701 N. E. Cullah St.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

0047

0048

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

00469

CERTIFICATE OF DEATH

00472

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN lb <u>43 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u> <u>13.1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Owings Mills, Md.</u>		d. STREET ADDRESS <u>Chattolane Hill</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Dostick</u> Middle <u>Whitman</u> Last		4. DATE OF DEATH <u>January</u> <u>26, 1967</u> Month <u>26</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1888</u>
9. AGE (In years lost, birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>D.C.</u>	
13. FATHER'S NAME <u>Charles S. Whitman</u>		14. MOTHER'S MAIDEN NAME <u>Nancy deSaurre Dostick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes.</u> <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mr. Edward D. Whitman, Owings Mills, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>myocardial infarction acute</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1948, 1948</u> to <u>Jan 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 25, 1967</u> , and that death occurred at <u>3:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Palmer F.C. Williams</u>		22b. DATE SIGNED <u>Jan 28, '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Palmer F.C. Williams</u>		22d. ADDRESS <u>Lawson Rd. Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Owings Mills, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Kildesville</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 31 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00470

Item 2 Film G384 1/10/67 mh

CERTIFICATE OF DEATH

00473

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Prince George Co. Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN lb 2yr. 6mo. 21da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 6305 Eastern Ave N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD WILLIS			4. DATE OF DEATH Month Day Year Jan. 1 19 67				
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-86		9. AGE (In years lost birthday) 80 Yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a) NONE, EXCEPT Senility						INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from June 10, 1964 , to Jan. 1, 1967 , that we (we) lost saw the deceased alive on January 1, 1967 , and that death occurred at 4:25 AM , from causes and on the date stated above.							
22a. SIGNATURE Allen W. Lane			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 1, 1967		
22c. PHYSICIAN'S NAME (Type) Allen W. Lane			22d. ADDRESS Spring Grove State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/5/67	23c. NAME OF CEMETERY OR CREMATORY Int. Direct.		23d. LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR JOHN T. RYAN JR			ADDRESS 3015 1/2 A. ST. E. Wash. DC.		25a. REC'D BY REGISTRAR DATE JAN 5 1967		
						25b. REGISTRAR'S SIGNATURE Charles Judge	

00470

00470

DATE OF BIRTH: 1-10-38

DATE OF DEATH: 1-10-38

DATE OF BURIAL: 1-10-38

DATE OF CREMATION: 1-10-38

DATE OF INTERMENT: 1-10-38

DATE OF EXHUMATION: 1-10-38

DATE OF REINTERMENT: 1-10-38

DATE OF REINTERMENT: 1-10-38

DATE OF REINTERMENT: 1-10-38

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1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00471

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00474

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) c. LENGTH OF STAY IN b Essex (21) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 272 Holly Neck Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) d. STREET ADDRESS Box 272 Holly Neck Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES JAMES WOLFE				4. DATE OF DEATH Month Day Year January 12 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1900	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster				10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Wolfe				14. MOTHER'S MAIDEN NAME Lula Bradyhouse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218-03-8781		17. INFORMANT Margaret Wolfe Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) A-S-C-V-Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE M B Davis M D EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Mornington Rd. Dundalk, Md. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 12, 1967							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/67		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR James Bruzdinski ADDRESS Bruzdinski Funeral Home 1407 Eastern Ave. #21				24a. REC'D BY REGISTRAR JAN 16 1967 24b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit form. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00473

00473

Box (21)

Box (21)

Box 125 Holly Brook Rd.

Box 125 Holly Brook Rd.

CHARLES JAMES WOLF

January 12

Male White

Sept. 14, 1900

Residence

Residence

Residence

USA

Wife's name

Wife's name

No

510-03-5001

January 12, 1907

Box 125 Holly Brook Rd.

Box (21)

Box (21)

Box (21)

Box 125 Holly Brook Rd.

Box 125 Holly Brook Rd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 201 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00472														
00475														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN TB <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			d. STREET ADDRESS <u>77 Winter Avenue</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>77 Winters Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Woodland</u>					4. DATE OF DEATH Month <u>January</u> Day <u>9th.</u> Year <u>1967</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October-9th-1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retierd</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Catonsville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>						
13. FATHER'S NAME <u>Phillip Woodland</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Lee</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>?</u>					17. INFORMANT Address <u>Lucille Cephas</u> <u>Same</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>														
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.														
DUPLICATE <u>C.V. Disease</u>														
DUPLICATE <u>Chronic Nephritis, Gen. Ail.</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-66</u> to <u>1-9-67</u> that (I) (we) last saw the deceased alive on <u>1-7-67</u> and that death occurred at <u>12:20 PM</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>M.L. Weaver</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-10-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>M.L. Weaver M.D.</u>					22d. ADDRESS <u>1944 Druid Hill Avenue</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Catonsville Maryland</u>						
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stetson D. Wilson</u>					ADDRESS <u>523 North Calhoun St.</u>		25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

8400

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00473

00476

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks 21152 d. STREET ADDRESS Walters Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian First Middle Last WOODWARD		4. DATE OF DEATH January 4, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1901 9. AGE (In years lost birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not employed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Walters		14. MOTHER'S MAIDEN NAME Daisy Bell Shoppert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-07-6262D	
17. INFORMANT Mrs. Vivian Corbin Same as 2-D		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Subdural Cerebral Hemorrhage (b) Fracture Left Occipital Head DUE TO 4 1/2 inch x 3 1/2 inch Left Head (c) 2 1/2 inch x 3 1/2 inch Left Head PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 11 Days 5 1/2 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down Fight of Stars.	
20c. TIME OF INJURY Month, Day, Year 9:15 a.m. 1/3/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Sparks Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		22. DATE SIGNED 1/4/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 7, 1967	23c. NAME OF CEMETRY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson ADDRESS 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR JAN 6 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
00474					CERTIFICATE OF DEATH					00477				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234			13.1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 2428 Harwood Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Elmer Middle Howard Last Wright					4. DATE OF DEATH Month January Day 24 Year 1967									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 10-28-13		9. AGE (In years last birthday) yrs. 53		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Arts & Crafts Mater. Corp.			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME George Wright					14. MOTHER'S MAIDEN NAME Lottie Pratt									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 212-07-5473		17. INFORMANT Mrs. Naomi Wright Address 2428 Harwood Road									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Arteriosclerosis of Aorta DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan. 2nd , 1967, to Jan. 24th , 1967, that (I) (we) last saw the deceased alive on Jan. 24th , 1967, and that death occurred at 12:50 A.M. , from causes and on the date stated above.														
22a. SIGNATURE Pridipongse Vithespongse					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED Jan. 24th 1967						
22c. PHYSICIAN'S NAME (Type) Pridipongse Vithespongse					22d. ADDRESS M.D. 7620 York Road Towson 21204, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-27-1967		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Co. Md.							
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road					ADDRESS 36		25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

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00475

CERTIFICATE OF DEATH

00478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 95 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1725 THOMAS AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE GRIM YANCEY				4. DATE OF DEATH Month Day Year JANUARY 1 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14, 1919		9. AGE (In years last birthday) yrs. 47	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISHWASHER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) GRANVILLE, N.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLIE YANCEY				14. MOTHER'S MAIDEN NAME HATTIE WILKERSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 240 24 97 73		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 161X IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX WITH METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) STATUS POST LARYNGECTOMY AND RADICAL NECK DISSECTION							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-28 , 19 66 to 1-1 , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JAN 1 , 19 67 , and that death occurred at 4:56 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Milton Ginsberg</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/3/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-6-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR <i>Furnell B. Oden</i>				25a. REC'D BY REGISTRAR DATE JAN 4 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00476

CERTIFICATE OF DEATH

00476

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9 Delight Road				d. STREET ADDRESS 9 Delight Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian M. Yox		First Middle Last		4. DATE OF DEATH Month Day Year January 31, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 Year Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David L. Kendig				14. MOTHER'S MAIDEN NAME Laura Bieswanger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-9967		17. INFORMANT Address Mrs. Ethel V. VonGunten Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Bronchitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-30-42 , 19__, to 1-31-67 , 19__, that (I) (we) last saw the deceased alive on Jan. 25 , 19 67 , and that death occurred at 8 A M, from causes and on the date stated above.							
22a. SIGNATURE D. D. Caples				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-1-67	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/67		23c. NAME OF CEMETERY OR CREMATORY All Saints		23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.	
24. FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR DATE FEB 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00480

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 c. LENGTH OF STAY IN lb Baltimore 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 505 Regester Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 505 Regester Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Salvatore First Middle Last Zito		4. DATE OF DEATH Month Day Year 1-7-1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-1899 9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Owner		10b. KIND OF BUSINESS OR INDUSTRY Meat	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Zito	
14. MOTHER'S MAIDEN NAME Rose Fertitta		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-32-2799		17. INFORMANT Mrs. Minnie M. Zito Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO 16 yrs (c) With Insults		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) Dr. Charles F. O'Donnell		22. DATE SIGNED 1/1/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-5-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd., Balto.		25a. REC'D BY REGISTRAR JAN 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



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